Chapter 246-976 WAC
EMERGENCY MEDICAL SERVICES AND TRAUMA CARE SYSTEMS

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WAC

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246-976-020 First responder training—Course contents, registration, instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-020, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-021 Training course requirements. [Statutory Authority: RCW 18.71.205, 18.73.081, and 43.70.615. WSR 08-10-091, § 246-976-021, filed 5/6/08, effective 6/6/08. Statutory Authority: RCW 18.71.205, 18.73.081, and 70.168.060. WSR 03-20-107, § 246-976-021, filed 10/1/03, effective 11/1/03. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-021, filed 4/5/00, effective 5/6/00.] Repealed by WSR 11-07-078, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-025 First responder—Continuing medical education. [Statutory Authority: RCW 43.70.040, chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-025, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-030 Emergency medical technician training—Course content, registration, and instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-030, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-035 Emergency medical technician—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-035, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-040 Specialized training. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-040, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-045 Levels of intermediate life support personnel and advanced life support paramedics. [Statutory Authority: Chapter 18.71 RCW. WSR 96-03-052, § 246-976-045, filed 1/12/96, effective 2/12/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-050 Intravenous therapy technician training—Course content, registration, instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-050, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-055 Intravenous therapy technicians—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-055, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-060 Airway technician training—Course content, registration, instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-060, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-065 Airway technician—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-065, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-070 Combined intravenous therapy and airway technician training—Course content, registration, instructor qualifications. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-070, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-075 IV therapy/airway technician—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-075, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-076 Intermediate life support training—Course content, registration, instructor qualifications. [Statutory Authority: Chapter 18.71 RCW. WSR 96-17-067, § 246-976-076, filed 8/20/96, effective 9/20/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-077 Intermediate life support technicians—Continuing medical education. [Statutory Authority: Chapter 18.71 RCW. WSR 96-17-067, § 246-976-077, filed 8/20/96, effective 9/20/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-080 Paramedic training—Course content. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-080, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-085 Paramedic—Continuing medical education. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-085, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-090 Continuing medical education—Units of learning. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-090, filed 12/23/92, effective 1/23/93.] Repealed by WSR 97-20-101, filed 9/29/97, effective 10/30/97. Statutory Authority: RCW 43.70.040.

246-976-110 Senior EMT instructor—Qualifications and responsibilities. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-110, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-115 Course coordinator—Responsibilities. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-115, filed 12/23/92, effective 1/23/93.] Repealed by WSR 97-20-101, filed 9/29/97, effective 10/30/97. Statutory Authority: RCW 43.70.040.

246-976-120 Disciplinary action—Training personnel. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-120, filed 12/23/92,

effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-140 Certification and recertification—General requirements. [Statutory Authority: Chapter 18.71 RCW. WSR 96-17-067, § 246-976-140, filed 8/20/96, effective 9/20/96. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-140, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-150 Certification and recertification—First responder. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-150, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-151 Reciprocity, challenges, reinstatement and other actions. [Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-151, filed 4/5/00, effective 5/6/00.] Repealed by WSR 11-07-078, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-160 Certification and recertification—Emergency medical technician. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-160, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-165 Levels of certified intermediate life support personnel and paramedics. [Statutory Authority: Chapter 18.71 RCW. WSR 96-03-052, § 246-976-165, filed 1/12/96, effective 2/12/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-170 Certification and recertification—Intravenous therapy technicians. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-170, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-180 Certification and recertification—Airway technicians. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-180, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-181 Certification and recertification—Intermediate life support technician. [Statutory Authority: Chapter 18.71 RCW. WSR 96-17-067, § 246-976-181, filed 8/20/96, effective 9/20/96.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-190 Recertification—IV and airway technicians. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-190, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-200 Certification and recertification—Paramedics. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-200, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-210 Certification—Reciprocity, challenges, and reinstatement. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-210, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-220 EMS personnel—Scope of care authorized, prohibited. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-220, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-230 Certification—Reversion, revocation, suspension, modification, or denial. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-230, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-240 Notice of decision and hearing. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-240, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-280 Ground ambulance and aid services—Personnel requirements. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-280, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-350 Ambulance and aid services—Variances from requirements. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-350, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-370 Ambulance and aid services—Prehospital trauma triage procedures. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-370, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-440 Trauma registry—Reports. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-440, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-450 Access and release of trauma registry information. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-450, filed 12/23/92, effective 1/23/93.] Repealed by WSR 00-08-102, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

246-976-470 Trauma care facilities—Designation process. [Statutory Authority: Chapter 70.168 RCW. WSR 93-20-063, § 246-976-470, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-470, filed 12/23/92, effective 1/23/93.] Repealed by WSR 98-04-038, filed 1/29/98, effective 3/1/98. Statutory Authority: Chapter 70.168 RCW.

246-976-475 On-site review for designation. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-475, filed 12/23/92, effective 1/23/93.] Repealed by WSR 98-04-038, filed 1/29/98, effective 3/1/98. Statutory Authority: Chapter 70.168 RCW.

246-976-480 Denial, revocation, or suspension of designation. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-480, filed 12/23/92, effective 1/23/93.] Repealed by WSR 98-04-038, filed 1/29/98, effective 3/1/98. Statutory Authority: Chapter 70.168 RCW.

246-976-485 Designation of facilities to provide trauma care services. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-485, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-485, filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-490 Suspension or revocation of designation. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-490, filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-500 Designation standards for facilities providing level I trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-500, filed 6/5/02, effective 7/6/02; WSR 98-04-038, § 246-976-500, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-500, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-510 Designation standards for facilities providing level I trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-510, filed 6/5/02, effective 7/6/02; WSR 98-04-038, § 246-976-510, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-510, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-510, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-520 Designation standards for facilities providing level I trauma care service—Outreach, public education, trauma care education, and research. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-520, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-520, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-520, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-530 Trauma service designation—Administration and organization. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-530, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-535 Trauma service designation—Basic resources and capabilities. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-535, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-540 Trauma service designation—Outreach, public education, provider education, and research. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-540, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-550 Designation standards for facilities providing level II trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-550, filed 6/5/02, effective 7/6/02; WSR 98-04-038, § 246-976-550, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-550, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-560 Designation standards for facilities providing level II trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-560, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-560, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-560, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-560, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-560, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-570 Designation standards for facilities providing level II trauma care service—Outreach, public education and trauma care education. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-570, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-570, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-600 Designation standards for facilities providing level III trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-600, filed 6/5/02, effective 7/6/02; WSR 98-04-038, § 246-976-600, filed 1/29/98,

effective 3/1/98; WSR 93-20-063, § 246-976-600, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-600, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-610 Designation standards for facilities providing level III trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-610, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-610, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-610, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-610, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-610, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-615 Designation standards for facilities providing level III trauma care service—Trauma care education. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-615, filed 1/29/98, effective 3/1/98.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-620 Equipment standards for trauma service designation. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-620, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-620, filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-640 Designation standards for facilities providing level IV trauma care services—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-640, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-640, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-650 Designation standards for facilities providing level IV trauma care services—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-650, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-650, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-650, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-650, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-650, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-680 Designation standards for facilities providing level V trauma care services—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-680, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-680, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-680, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-690 Designation standards for facilities providing level V trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-690, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-690, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-720 Designation standards for facilities providing level I pediatric trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-720, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-720, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-720, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-720, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-720, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-730 Designation standards for facilities providing level I pediatric trauma care services—Resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-730, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-730, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-730, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-730, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-730, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-740 Designation standards for facilities providing level I pediatric trauma care service—Outreach, public education, trauma care education, and research. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-740, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-740, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-750 Pediatric trauma service designation—Administration and organization. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-750, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-755 Pediatric trauma service designation—Basic resources and capabilities. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-755, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-760 Pediatric trauma service designation—Outreach, public education, provider education, and research. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-760, filed 12/10/03, effective 1/10/04.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-770 Designation standards for facilities providing level II pediatric trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-770, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-770, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-770, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-770, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-770, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-780 Designation standards for facilities providing level II pediatric trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-780, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-780, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-780, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-780, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-780, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-790 Designation standards for facilities providing level II pediatric trauma care service—Outreach, public education, and trauma care education. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-790, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-790, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-790, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-810 Designation standards for facilities providing level III pediatric trauma care service—Administration and organization. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-810, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-810, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-810, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-810, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-810, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-820 Designation standards for facilities providing level III pediatric trauma care service—Basic resources and capabilities. [Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-820, filed 6/5/02, effective 7/6/02; WSR 98-19-107, § 246-976-820, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-820, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-820, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-820, filed 12/23/92, effective 1/23/93.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-822 Designation standards for facilities providing level III pediatric trauma care service—Trauma care education. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-822, filed 1/29/98, effective 3/1/98.] Repealed by WSR 04-01-041, filed 12/10/03, effective 1/10/04. Statutory Authority: RCW 70.168.060 and 70.168.070.

246-976-830 Designation standards for facilities providing level I trauma rehabilitation service. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-830, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-830, filed 10/1/93, effective 11/1/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-840 Designation standards for facilities providing level II trauma rehabilitation service. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-840, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-840, filed 10/1/93, effective 11/1/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-850 Designation standards for level III trauma rehabilitation service. [Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-850, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-850, filed 10/1/93, effective 11/1/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-860 Designation standards for facilities providing level I pediatric trauma rehabilitation service. [Statutory Authority: Chapter 70.168 RCW. WSR 98-19-107, § 246-976-860, filed 9/23/98, effective 10/24/98; WSR 98-04-038, § 246-976-860, filed 1/29/98, effective 3/1/98; WSR 93-20-063, § 246-976-860, filed 10/1/93, effective 11/1/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-870 Trauma team activation. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-870, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-870, filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-880 Trauma quality assurance programs for designated trauma care hospitals. [Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-880, filed 12/23/92, effective 1/23/93.] Repealed by WSR 98-04-038, filed 1/29/98, effective 3/1/98. Statutory Authority: Chapter 70.168 RCW.

246-976-881 Trauma quality improvement programs for designated trauma care services. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-881, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-881,

filed 1/29/98, effective 3/1/98.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-885 Educational requirements—Designated trauma care service personnel. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-885, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-885, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-885, filed 12/23/92, effective 1/23/93.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-886 Pediatric education requirements (PER) for nonpediatric designated facilities. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-886, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-886, filed 6/5/02, effective 7/6/02.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-887 Pediatric education requirements (PER) for pediatric designated facilities. [Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-887, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapter 70.168 RCW. WSR 02-12-107, § 246-976-887, filed 6/5/02, effective 7/6/02.] Repealed by WSR 09-23-085, filed 11/16/09, effective 12/17/09. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070.

246-976-950 Licensing and certification committee. [Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-950, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-950, filed 12/23/92, effective 1/23/93.] Repealed by WSR 11-07-078, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW.

WAC 246-976-001 Purpose. The purpose of these rules is to implement RCW 18.71.200 through 18.71.215, and chapters 18.73 and 70.168 RCW; and those sections of chapter 70.24 RCW relating to EMS personnel and services.

(1) This chapter establishes criteria for:

(a) Training and certification of EMS providers;

(b) Licensure and inspection of ambulance services and aid services;

(c) Verification of prehospital trauma services;

(d) Development and operation of a statewide trauma registry;

(e) The designation process and operating requirements for designated trauma care services;

(f) A statewide emergency medical communication system;

(g) Administration of the statewide EMS/TC system.

(2) This chapter does not contain detailed procedures to implement the state EMS/TC system. Requests for procedures, guidelines, or any publications referred to in this chapter must be obtained from the Office of Community Health Systems, Department of Health, Olympia, WA 98504-7853 or on the internet at www.doh.wa.gov.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-001, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-001, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-001, filed 12/23/92, effective 1/23/93.]

WAC 246-976-010 Definitions. Definitions in RCW 18.71.200, 18.71.205, 18.73.030, and 70.168.015 and the definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Activation of the trauma system" means mobilizing resources to care for a trauma patient in accordance with regional patient care procedures.

(2) "Adolescence" means the period of physical and psychological development from the onset of puberty to maturity, approximately twelve to eighteen years of age.

(3) "Advanced cardiac life support (ACLS)" means a course that includes the education and clinical interventions used to treat cardiac arrest and other acute cardiac related problems.

(4) "Advanced emergency medical technician (AEMT)" means a person who has been examined and certified by the secretary as an intermediate life support technician as defined in RCW 18.71.200 and 18.71.205.

(5) "Advanced first aid" means an advanced first-aid course prescribed by the American Red Cross or its equivalent.

(6) "Advanced life support (ALS)" means invasive emergency medical services requiring the advanced medical treatment skills of a paramedic.

(7) "Agency" means an aid or ambulance service licensed by the secretary to provide prehospital care or interfacility ambulance transport.

(8) "Agency response time" means the interval from dispatch to arrival on the scene.

(9) "Aid service" means an agency licensed by the secretary to operate one or more aid vehicles, consistent with regional and state plans.

(10) "Ambulance service" means an agency licensed by the secretary to operate one or more ground or air ambulances.

(11) "Approved" means approved by the department of health.

(12) "ATLS" means advanced trauma life support, a course developed by the American College of Surgeons.

(13) "Attending surgeon" means a physician who is board-certified or board-qualified in general surgery, and who has surgical privileges delineated by the facility's medical staff. The attending surgeon is responsible for care of the trauma patient, participates in all major therapeutic decisions, and is present during operative procedures.

(14) "Available" for designated trauma services described in WAC 246-976-485 through 246-976-890 means physically present in the facility and able to deliver care to the patient within the time specified. If no time is specified, the equipment or personnel must be available as reasonable and appropriate for the needs of the patient.

(15) "Basic life support (BLS)" means emergency medical services requiring basic medical treatment skills as defined in chapter 18.73 RCW.

(16) "Board certified" or "board-certified" means that a physician has been certified by the appropriate specialty board recognized by the American Board of Medical Specialties. For the purposes of this chapter, references to "board certified" include physicians who are board-qualified.

(17) "Board-qualified" means physicians who have graduated less than five years previously from a residency program accredited for the appropriate specialty by the accreditation council for graduate medical education.

(18) "BP" means blood pressure.

(19) "Certification" means the secretary recognizes that an individual has proof of meeting predetermined qualifications, and authorizes the individual to perform certain procedures.

(20) "Consumer" means an individual who is not associated with the EMS/TC system, either for pay or as a volunteer, except for service on the steering committee, or regional or local EMS/TC councils.

(21) "Continuing medical education method" or (CME method) means prehospital EMS recertification education required after initial EMS certification to maintain and enhance skill and knowledge. The CME

method requires the successful completion of department-approved knowledge and practical skill certification examinations to recertify.

(22) "County operating procedures" or "COPS" means the written operational procedures adopted by the county MPD and the local EMS council specific to county needs.

(23) "CPR" means cardiopulmonary resuscitation.

(24) "Critical care transport" means the interfacility transport of a patient whose condition requires care by a physician, RN or a paramedic who has received special training and approval by the MPD.

(25) "Department" means the Washington state department of health.

(26) "Dispatch" means to identify and direct an emergency response unit to an incident location.

(27) "Diversion" means the EMS transport of a patient past the usual receiving facility to another facility due to temporary unavailability of care resources at the usual receiving facility.

(28) "E-code" means external cause code, an etiology included in the International Classification of Diseases (ICD).

(29) "ED" means emergency department.

(30) "Emergency medical procedures" means the skills that are performed within the scope of practice of EMS personnel certified by the secretary under chapters 18.71 and 18.73 RCW.

(31) "Emergency medical services and trauma care (EMS/TC) system" means an organized approach to providing personnel, facilities, and equipment for effective and coordinated medical treatment of patients with a medical emergency or injury requiring immediate medical or surgical intervention to prevent death or disability. The emergency medical services and trauma care system includes prevention activities, prehospital care, hospital care, and rehabilitation.

(32) "Emergency medical responder (EMR)" means a person who has been examined and certified by the secretary as a first responder to render prehospital EMS care as defined in RCW 18.73.081.

(33) "Emergency medical technician (EMT)" means a person who has been examined and certified by the secretary as an EMT to render prehospital EMS care as defined in RCW 18.73.081.

(34) "EMS" means emergency medical services.

(35) "EMS provider" means an individual certified by the secretary or the University of Washington School of Medicine under chapters 18.71 and 18.73 RCW to provide prehospital emergency response, patient care, and transport.

(36) "EMS/TC" means emergency medical services and trauma care.

(37) "General surgeon" means a licensed physician who has completed a residency program in surgery and who has surgical privileges delineated by the facility.

(38) "ICD" means the international classification of diseases, a coding system developed by the World Health Organization.

(39) "Injury prevention" means any combination of educational, legislative, enforcement, engineering and emergency response initiatives used to reduce the number and severity of injuries.

(40) "Interfacility transport" means medical transport of a patient between recognized medical treatment facilities requested by a licensed health care provider.

(41) "Intermediate life support (ILS)" means invasive emergency medical services requiring the advanced medical treatment skills of an advanced EMT (AEMT).

(42) "IV" means a fluid or medication administered directly into the venous system.

(43) "Local council" means a local EMS/TC council authorized by RCW 70.168.120(1).

(44) "Medical control" means oral or written direction of medical care that certified prehospital EMS personnel provide to patients of all age groups. The oral or written direction is provided by the MPD or MPD delegate.

(45) "Medical control agreement" means a written agreement between two or more MPDs, using similar protocols that are consistent with regional plans, to assure continuity of patient care between counties, and to facilitate assistance.

(46) "Medical program director (MPD)" means a person who meets the requirements of chapters 18.71 and 18.73 RCW and is certified by the secretary. The MPD is responsible for both the supervision of training and medical control of EMS providers.

(47) "MPD delegate" means a physician appointed by the MPD and recognized and approved by the department. An MPD delegate may be:

(a) A prehospital training physician who supervises specified aspects of training EMS personnel; or

(b) A prehospital supervising physician who provides online medical control of EMS personnel.

(48) "Ongoing training and evaluation program (OTEP)" means a continuous program of prehospital EMS education for EMS personnel after completion of initial training. An OTEP is approved by the MPD and the department. An OTEP must meet the EMS education requirements and core topic content required for recertification. The OTEP method includes evaluations of the knowledge and skills covered in the topic content following each topic presentation.

(49) "PALS" means a pediatric advanced life support course.

(50) "Paramedic" or "physician's trained emergency medical service paramedic" means a person who has been trained in an approved program to perform all phases of prehospital emergency medical care, including advanced life support, under written or oral authorization of an MPD or approved physician delegate, examined and certified by the secretary under chapter 18.71 RCW.

(51) "Pediatric education requirement (PER)" means the pediatric education and training standards required for certain specialty physicians and nurses who care for pediatric patients in designated trauma services as identified in WAC 246-976-886 and 246-976-887.

(52) "PEPP" means pediatric education for prehospital professionals.

(53) "PHTLS" means a prehospital trauma life support course.

(54) "Physician" means an individual licensed under the provisions of chapters 18.71 or 18.57 RCW.

(55) "Physician with specific delineation of surgical privileges" means a physician with surgical privileges delineated for emergency/life-saving surgical intervention and stabilization of a trauma patient prior to transfer to a higher level of care. Surgery privileges are awarded by the facility's credentialing process.

(56) "Postgraduate year" means the classification system for residents who are undergoing postgraduate training. The number indicates the year the resident is in during his/her postmedical school residency program.

(57) "Practical skills examination" means a test conducted in an initial course, or a test conducted during a recertification period, to determine competence in each of the practical skills or group of skills specified by the department.

(58) "Prehospital index (PHI)" means a scoring system used to trigger activation of a hospital trauma resuscitation team.

(59) "Prehospital patient care protocols" means the department-approved, written orders adopted by the MPD under RCW 18.73.030(15) and 70.168.015(27) which direct the out-of-hospital care of patients. These protocols are related only to delivery and documentation of direct patient treatment. The protocols meet or exceed statewide minimum standards developed by the department in rule as authorized in chapter 70.168 RCW.

(60) "Prehospital provider" means EMS provider.

(61) "Prehospital trauma care service" means an agency that is verified by the secretary to provide prehospital trauma care.

(62) "Prehospital trauma triage procedure" means the method used by prehospital providers to evaluate injured patients and determine whether to activate the trauma system from the field. It is described in WAC 246-976-930(2).

(63) "Public education" means education of the population at large, targeted groups, or individuals, in preventive measures and efforts to alter specific injury, trauma, and medical-related behaviors.

(64) "Quality improvement (QI)" or "quality assurance (QA)" means a process/program to monitor and evaluate care provided in the EMS/TC system.

(65) "Regional council" means the regional EMS/TC council established by RCW 70.168.100.

(66) "Regional patient care procedures" means department-approved written operating guidelines adopted by the regional emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communication centers, and the emergency medical services medical program director, in accordance with statewide minimum standards. The patient care procedures identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients are consistent with the transfer procedures in chapter 70.170 RCW. Patient care procedures do not relate to direct patient care.

(67) "Regional plan" means the plan defined in WAC 246-976-960 (1)(b) that has been approved by the department.

(68) "Registered nurse" means an individual licensed under the provisions of chapter 18.79 RCW.

(69) "Rural" means an unincorporated or incorporated area with a total population of less than ten thousand people, or with a population density of less than one thousand people per square mile.

(70) "Secretary" means the secretary of the department of health.

(71) "Senior EMS instructor (SEI)" means an individual approved by the department to be responsible for the administration, quality of instruction and the conduct of initial emergency medical responder (EMR) and emergency medical technician (EMT) training courses.

(72) "Special competence" means that an individual has been deemed competent and committed to a medical specialty area with documented training, board certification and/or experience, which has been reviewed and accepted as evidence of a practitioner's expertise:

(a) For physicians, by the facility's medical staff;

(b) For registered nurses, by the facility's department of nursing;

(c) For physician assistants and advanced registered nurse practitioners, as defined in the facility's bylaws.

(73) "State plan" means the emergency medical services and trauma care system plan described in RCW 70.168.015(7), adopted by the department under RCW 70.168.060(10).

(74) "Steering committee" means the EMS/TC steering committee created by RCW 70.168.020.

(75) "Suburban" means an incorporated or unincorporated area with a population of ten thousand to twenty-nine thousand nine hundred ninety-nine or any area with a population density of between one thousand and two thousand people per square mile.

(76) "System response time" for trauma means the interval from discovery of an injury until the patient arrives at a designated trauma facility.

(77) "Training program" means an organization that is approved by the department to be responsible for specified aspects of training EMS personnel.

(78) "Trauma rehabilitation coordinator" means a person designated to facilitate early rehabilitation interventions and the trauma patient's access to a designated rehabilitation center.

(79) "Trauma response area" means a service coverage zone identified in an approved regional plan.

(80) "Trauma service" means the clinical service within a hospital or clinic that is designated by the department to provide care to trauma patients.

(81) "Urban" means:

(a) An incorporated area over thirty thousand; or

(b) An incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square mile.

(82) "Verification" means a prehospital agency is capable of providing verified trauma care services and is credentialed under chapters 18.73 and 70.168 RCW.

(83) "Wilderness" means any rural area not readily accessible by public or private maintained road.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-010, filed 3/22/11, effective 5/15/11; WSR 05-01-221, § 246-976-010, filed 12/22/04, effective 1/22/05; WSR 00-08-102, § 246-976-010, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapter 18.71 RCW. WSR 96-03-052, § 246-976-010, filed 1/12/96, effective 2/12/96. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-010, filed 12/23/92, effective 1/23/93.]

TRAINING

WAC 246-976-022 EMS training program requirements, approval, reapproval, discipline. (1) To apply for initial department approval as an EMS training program, applicants shall meet the requirements in Table A of this section.

Table A
EMS Training Program Requirements For Approval

REQUIREMENTS	
Organization type	Must be one of the following: • A local EMS and trauma care council or a county office responsible for EMS training for the county. This includes county agencies established by ordinance and approved by the MPD to coordinate and conduct EMS programs; • A regional EMS and trauma care council providing EMS training throughout the region; • An accredited institution of higher education; or • A private educational business, licensed as a private vocational school.
Optional organization	• If the organizations listed above do not exist or are unable to provide an EMS training program, the local EMS and trauma care council may recommend to the department another entity that is able to provide training. • In the absence of a local EMS council, the regional EMS and trauma care council may provide such recommendation. • Initial training courses conducted for licensed EMS agencies under the oversight of a department-approved EMS training program.
Need for new training program	Applicant must demonstrate need for new or additional EMS training programs.
Training program application	Complete a DOH EMS training program application on forms provided by the department indicating the levels of EMS training the program wants to conduct.
Class room and laboratory	Provide a description of classroom and laboratory facilities.
Training equipment and supplies	Provide a list of equipment and supplies on hand (or accessible) for use in the training program.
Course enrollment	For each level of EMS training applying for, provide a description of: • Course entry prerequisites; • Selection criteria; and • The process used to screen applicants.
Student handbook	Provide a student handbook for each level of EMS training applied for that provides:

REQUIREMENTS	
	• Training program policies, including minimum standards to enter training consistent with this chapter; • Course requirements and minimum standards required for successful completion of examinations, clinical/field internship rotations, and the EMS course; • Initial certification requirements the student must meet to become certified as identified in WAC 246-976-141; and • A listing of clinical and field internship sites available.

(2) Approved training programs shall meet the requirements in Table B of this section.

Table B
EMS Training Program Requirements

REQUIREMENTS	
General	An approved training program must: • Conduct courses following department requirements; • If conducting paramedic training courses, be accredited by a national accrediting organization approved by the department; • In conjunction with the course instructor, ensure course applicants meet the course application requirements in WAC 246-976-041; • Maintain clinical and field internship sites to meet course requirements, including the requirement that internship rotations on EMS vehicles must be performed as a third person, not replacing required staff on the vehicle; • For the purposes of program and course evaluation, provide to the department, county MPD, or MPD delegate access to all course related materials; • Conduct examinations over course lessons and other Washington state required topics; and • Participate in EMS and trauma care council educational planning.
Certification examination	Coordinate activities with the department-approved certification examination provider, including: • Registering the training program;

REQUIREMENTS	
	• Assisting students in registering with the examination provider; • Providing verification of cognitive knowledge and psychomotor skills for students successfully completing the EMS course; and • Assisting students in scheduling the examination.
Student records	Maintain student records for a minimum of four years.
Evaluation	Monitor and evaluate the quality of instruction for the purposes of quality improvement, including course examination scores for each level taught.
Reporting	Submit an annual report to the department which includes: • Annual, overall certification examination results; • A summary of complaints against the training program and what was done to resolve the issues; • Quality improvement activities including a summary of issues and actions to improve training results.

(3) To apply for reapproval, an EMS training program must meet the requirements in Table C of this section.

Table C
EMS Training Program Reapproval

REAPPROVAL	
Requirements	An EMS training program must be in good standing with the department and: • Have no violations of the statute and rules; • Have no pending disciplinary actions; • Maintain an overall pass rate of seventy-five percent on department-approved state certification examinations; • If conducting paramedic training courses, be accredited by a national accrediting organization approved by the department.
Reapplication	Complete: • The requirements in Tables A and B of this section; and • Submit an updated EMS training program application to the department at least six months prior to the program expiration date.

(4) Training program approval is effective on the date the department issues the certificate. Approval must be renewed every five years. The expiration date is indicated on the approval letter.

(5) Discipline of EMS training programs.

(a) The secretary may deny, suspend, modify, or revoke the approval of a training program when it finds:

(i) Violations of chapter 246-976 WAC;

(ii) Pending disciplinary actions;

(iii) Falsification of EMS course documents; or

(iv) Failure to update training program information with the department as changes occur.

(b) The training program may request a hearing to contest the secretary's decisions in regard to denial, suspension, modification, or revocation of training program approval in accordance with the Administrative Procedure Act (APA) (chapter 34.05 RCW) and chapter 246-10 WAC.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-022, filed 3/22/11, effective 5/15/11.]

WAC 246-976-023 Initial EMS training course requirements and course approval. To be approved to conduct each initial EMS training course, an EMS training program must:

(1) Meet the requirements identified in Table A of this section;

(2) Submit a completed EMS course training application on forms provided by the department, postmarked or received by the department at least three weeks prior to the course start date identified on the application;

(3) Have the approval of the training program's medical director and the recommendation for approval from the county medical program director; and

(4) Have written course approval from the department.

Table A
Initial EMS Training Course Requirements

REQUIREMENTS
The EMS training program must: • If conducting paramedic training courses, be accredited by a national accrediting organization approved by the department; • With the course SEI or lead instructor, ensure course applicants meet the course application requirements in WAC 246-976-041; • Supply each student with a student handbook as specified in WAC 246-976-022; • Provide each student, prior to beginning their field internship rotations, current, county specific, county medical program director field protocols and any specific information they will need while completing the internship; and • Use field internship preceptors who monitor and evaluate students in a standard and consistent manner.
EMS course SEI or lead instructor: The EMS course instructors identified in this section, under the general supervision of the county medical program director (MPD) are responsible: • For the overall conduct of the course, quality of instruction, and administrative paperwork; • For following the course curricula or instructional guidelines for the level of training conducted; • For evaluating the students' knowledge and practical skills throughout the course;

REQUIREMENTS
• For providing on-site instruction during each class and to supervise any other course instruction, unless arrangements have been made for another SEI or lead instructor to supervise. When using other instructors, the SEI or lead need not be physically present but must be immediately available for consultation.
Emergency medical responder (EMR) and EMT courses: The course instructor must be a department-approved SEI. An SEI candidate may instruct under the supervision of the SEI for the purpose of demonstrating instructional proficiency to the SEI.
AEMT courses: The course instructor for advanced EMT courses must be: • An AEMT that is recognized by the department as an SEI; or • A paramedic; or • Program instructional staff when training is provided by an accredited paramedic training program; and • Approved by the county medical program director.
Paramedic/EMT-paramedic courses: • The lead instructor for paramedic courses must have proof of clinical experience at the paramedic level or above; and • Must have the approval of the training program's medical director and the county medical program director.
EMS Evaluators: • Evaluators must be MPD and department-approved EMS evaluators; • EMS evaluators for EMR and EMT courses must be certified at the EMT level or higher; • EMS evaluators for advanced EMT courses must be certified at the AEMT or paramedic level.
Other instructors that may instruct individual course lessons when knowledgeable and skilled in the topic, approved by the MPD and under supervision of the SEI or lead instructor: • Guest instructors; • Department-approved EMS evaluators, to assist the SEI or lead instructor in the instruction of the course, who must be certified at or above the level of education provided; and • The MPD, MPD delegate or other physicians approved by the MPD.
Course curriculum or instructor guidelines: *The National Emergency Medical Services Training Standards - Instructor Guidelines* published January 2009 for the level of instruction; and • Instruction in multicultural health appropriate to the level of training; and • A department-approved, four hour infectious disease training program that meets the requirements of chapter 70.24 RCW; and • Other training consistent with MPD protocols.
EMS course practical skill evaluations:
SEIs or department-approved EMS evaluators conduct psychomotor evaluations during the course and provide corrective instruction for students. For EMR and EMT courses, evaluators must be certified as an EMT or higher level.
End of course practical skill examinations: Department-approved SEIs or department-approved EMS evaluators must conduct practical skill examinations. For EMR and EMT courses, evaluators must be certified at the EMT level or higher.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-023, filed 3/22/11, effective 5/15/11.]

WAC 246-976-024 EMS specialized training. (1) MPDs may submit a proposal to conduct pilot training programs to determine the need for skills, techniques, or equipment that is not included in standard course curricula/instructional guidelines. A pilot program allows the MPD to conduct field research to determine:

(a) The effectiveness of the training;

(b) EMS provider knowledge and skills competency;

(c) EMS provider ability to provide proper patient care after the training.

(2) To request approval of a pilot training program, the MPD must submit a proposal which includes the following information to the department for review:

(a) A needs statement describing what the proposed pilot will address;

(b) The level of certified EMS provider who will be participating in the pilot training;

(c) The length of the pilot project;

(d) The method by which the pilot project will be evaluated;

(e) Course curriculum/lesson plans;

(f) Type of instructional personnel required to conduct the pilot training;

(g) Course prerequisites;

(h) Criteria for successful course completion, including student evaluations and/or examinations; and

(i) Prehospital patient care protocols for use in the pilot program.

(3) The department will:

(a) Review the request and training plan;

(b) Consult with the prehospital technical advisory committee to determine the need for, and the benefits of the requested training throughout the state.

(c) Based on recommendation of the prehospital TAC, approve or deny the request for the pilot program.

(4) The MPD must report the results of the pilot training to the department and the prehospital TAC.

(5) The department and the prehospital TAC will review the results of the pilot training project to determine whether or not the new training will be implemented statewide.

(6) If the pilot training is approved for statewide use, the department will adopt it as specialized training and notify all county MPDs to advise if the skill is required or not.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-024, filed 3/22/11, effective 5/15/11.]

WAC 246-976-031 Senior EMS instructor (SEI) approval. (1) **Responsibilities and requirements.**

(a) The SEI is responsible for the overall instructional quality and the administrative paperwork associated with initial EMR or EMT courses, under the general supervision of the MPD.

(b) The SEI must:

(i) Follow department-approved curricula/instructional guidelines identified in WAC 246-976-023;

(ii) Ensure course applicants meet the course application requirements in WAC 246-976-041; and

(2) To become an approved SEI, an EMS provider must meet the requirements identified in Table A of this section.

Table A
Requirements For Initial Senior EMS Instructor Approval

REQUIREMENTS
Prerequisites:

REQUIREMENTS

Candidates for initial recognition must submit proof of successful completion of the following prerequisites to the department. Candidates meeting the prerequisites will be issued the *Initial Recognition Application Procedures (IRAP) for Senior EMS Instructors*, which include the *Initial Senior EMS Instructor Application and Agreement*, instructor objectives, instructions and forms necessary for initial recognition:

- Current Washington state certification at the EMT or higher EMS certification level;
- At least three years prehospital EMS experience at the EMT or higher EMS certification level, with at least one recertification;
- Approval as an EMS evaluator as identified in WAC 246-976-161;
- Current recognition as a health care provider level CPR instructor from a nationally recognized training program for CPR, foreign body airway obstruction (FBAO), and defibrillation;
- Successful completion of an instructor training course by the U.S. Department of Transportation, National Highway Traffic Safety Administration, an instructor training course from an accredited institution of higher education, or equivalent instructor course approved by the department;
- Pass an examination developed and administered by the department on current EMS training and certification statutes, Washington Administrative Code (WAC), the Uniform Disciplinary Act (UDA) and course administration.

Candidate objectives:

Candidates must successfully complete the IRAP under the supervision of a currently recognized SEI.

As part of an initial EMT course, the candidate must demonstrate to the course lead SEI the knowledge and skills necessary to complete the following instructor objectives:

- Accurately complete the course application process and meet application timelines;
- Notify potential EMT course applicants of course entry prerequisites;
- Assure that applicants selected for admittance to the course meet department training and certification prerequisites;
- Maintain course records;
- Track student attendance, scores, quizzes, and performance, and counsel/remediate students as necessary;
- Assist in the coordination and instruction of one entire EMT course, including practical skills, under the supervision of the course lead SEI using the EMT training course instructor guidelines identified in WAC 246-976-023, and be evaluated on the instruction of each of the following sections/lessons:
  - Preparatory section, including *Infectious Disease Prevention for EMS Providers*, Revised 01/2009;
  - Airway section;
  - Assessment section;
  - Pharmacology section;
  - Medical section, Cardiovascular and Respiratory lessons;
  - Special Patient Populations section, Obstetrics, Neonatal Care, and Pediatrics lessons;
  - Trauma section, Head, Facial, Neck and Spine Trauma and Chest Trauma lessons;
  - EMS Operations section, Vehicle Extrication, Incident Management, and Multiple Casualty Incidents lessons; and
  - Multicultural Awareness component.
- Coordinate and conduct an EMT final end of course comprehensive practical skills evaluation.

Candidate evaluation:

Performance evaluations must be conducted by an SEI for each instructor objective performed by the candidate on documents identified in the IRAP. These documents consist of:

- An evaluation form, to evaluate lesson instruction objectives performed by the candidate;
- A quality improvement record, to document improvement necessary to successfully complete an instructor objective performed by the candidate; and
- An objective completion record, to document successful completion of each instructor objective performed by the candidate.

Application:

Submit the following documents to the county MPD to obtain a recommendation:

- The original initial SEI application/agreement, signed by the candidate; and

REQUIREMENTS
• The original completed IRAP, all objective completion records, and evaluation documents. The completed application must be submitted to the department including: • The original application signed by both the candidate and the MPD; • The original completed IRAP, all objective completion records, and evaluation documents.

(3) SEI approval is effective on the date the department issues the certification card. Certifications must be renewed every three years. The expiration date is indicated on the certification card.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-031, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 18.73.081 and 70.168.120. WSR 02-14-053, § 246-976-031, filed 6/27/02, effective 7/28/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-031, filed 4/5/00, effective 5/6/00.]

WAC 246-976-032 Senior EMS instructor (SEI) reapproval of recognition. (1) To become reapproved, an SEI must meet the requirements identified in Table A of this section.

(2) The renewal application procedures (RAP) will be provided by the department to individuals upon recognition as an SEI. The RAP must be completed by the SEI during the recognition period.

Table A
Requirements For Senior EMS Instructor Reapproval

REQUIREMENTS
Prerequisites: Document proof of completion of the following prerequisites: • Current or previous recognition as a Washington state SEI; • Current Washington state certification at the EMT or higher EMS certification level; • Current recognition as a health care provider level CPR instructor from a nationally recognized training program for CPR, foreign body airway obstruction (FBAO), and defibrillation; • Pass an examination developed and administered by the department on current EMS training and certification statutes, Washington Administrative Code (WAC), the Uniform Disciplinary Act (UDA) and course administration.
Candidate objectives: Successfully complete the following objectives for each recognition period: • Coordinate and perform as the lead SEI for one initial EMR or EMT course including the supervision of all practical skills evaluations; • Receive performance evaluations from a currently recognized SEI, on two candidate instructed EMR or EMT course lessons; • Perform two performance evaluations on the instruction of EMR or EMT course lessons for SEI initial or renewal recognition candidates; and • Attend one department-approved SEI or instructor improvement workshop.
Candidate evaluation: Evaluations of the performance of instructor objectives will be conducted by an SEI and completed on documents identified in the RAP. These documents consist of; • An evaluation form, to evaluate lesson instruction objectives performed by the candidate; • A quality improvement record, to document improvement necessary to successfully complete an instructor objective performed by the candidate; and • An objective completion record, to document successful completion of each instructor objective performed by the candidate.

REQUIREMENTS
Application: Submit the documented prerequisites and the completed RAP, including the application/agreement and all documents completed during the renewal of recognition process, to the county MPD to obtain a recommendation. The completed application must be submitted to the department including: • Current proof of successful completion of the prerequisites listed in this section; • The original SEI renewal application/agreement that has been signed by the candidate and the county MPD; and • The original completed RAP document and all forms used for evaluation, quality improvement purposes and verification of successful completion as identified in the RAP.

(3) An EMS instructor approved in another state, country, or U.S. military branch may obtain reciprocal recognition. To become an SEI, the applicant must:

(a) Meet the initial recognition prerequisites as defined in this section;

(b) Provide proof of at least three years of instructional experience as a state approved EMS instructor. If the applicant cannot provide proof of instructional experience, the initial recognition application process must be completed;

(c) Instruct two initial EMT course topics, be evaluated on the instruction by a current Washington SEI, and receive a positive recommendation for approval by the SEI; and

(d) Complete the renewal application and submit it to the department.

(4) An SEI whose recognition has expired for more than twelve months must complete the initial recognition process.

(5) Approval is effective on the date the department issues the certificate. Certifications must be renewed every three years. The expiration date is indicated on the certification card.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-032, filed 3/22/11, effective 5/15/11.]

WAC 246-976-033 Denial, suspension, modification or revocation of SEI recognition. (1) The secretary may deny, suspend, modify or revoke an SEI's recognition when it finds the SEI has:

(a) Violated chapter 18.130 RCW, the Uniform Disciplinary Act;

(b) Failed to:

(i) Maintain EMS certification;

(ii) Update the following personal information with the department as changes occur:

(A) Name;

(B) Address;

(C) Home and work phone numbers;

(iii) Maintain knowledge of current EMS training and certification statutes, WAC, the UDA, and course administration;

(iv) Comply with requirements in WAC 246-976-031(1);

(v) Participate in the instructor candidate evaluation process in an objective and professional manner without cost to the individual being reviewed or evaluated;

(vi) Complete all forms and maintain records in accordance with this chapter;

(vii) Demonstrate all skills and procedures based on current standards;

(viii) Follow the requirements of the Americans with Disabilities Act; or

(ix) Maintain security on all department-approved examination materials.

(2) The candidate or SEI may request a hearing to contest the secretary's decisions in regard to denial, suspension, modification or revocation of SEI recognition in accordance with the Administrative Procedure Act (APA) (chapter 34.05 RCW), the Uniform Disciplinary Act (chapter 18.130 RCW), and chapter 246-10 WAC.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-033, filed 3/22/11, effective 5/15/11.]

WAC 246-976-041 To apply for training. (1) An applicant for EMS training must be at least seventeen years old at the beginning of the course. Variances will not be allowed for the age requirement.

(2) An applicant for training at the intermediate (AEMT) level, must be currently certified as an EMT with at least one year of experience.

(3) An applicant for training at the advanced life support (paramedic) level, must have at least one year of experience as a certified EMT, or equivalent prehospital experience and meet all entry requirements of the state approved paramedic training program.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-041, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-041, filed 4/5/00, effective 5/6/00.]

CERTIFICATION

WAC 246-976-141 To obtain initial EMS provider certification following the successful completion of Washington state approved EMS course. To apply for initial EMS provider certification following the successful completion of a Washington state approved EMS course, an applicant must submit to the department:

(1) A completed initial certification application on forms provided by the department.

(2) Proof of meeting the requirements identified in Table A of this section.

Table A
Applicants Who Have Completed a Washington State Approved EMS Course

REQUIREMENTS
EMS education:
Candidate must provide proof of successful EMS course completion from a department-approved EMS training program. For paramedic applicants, this proof must be from a training program accredited by a department-approved national accrediting organization.
Certification examination:
Provide proof of a passing score on the department-approved certification examination for the level of certification. Applicants will have three attempts within twelve months of course completion to pass the examination.
After three unsuccessful attempts, the applicant may retake the initial EMS training course, or within twelve months of the third unsuccessful attempt, complete department-approved refresher training covering airway, medical, pediatric, and trauma topics identified below, and pass the department-approved certification examination:

REQUIREMENTS
• EMR Not applicable. Must repeat EMR course. • EMT twenty-four hours. • AEMT thirty-six hours - Pharmacology review must be included in the refresher training. • Paramedic forty-eight hours - Pharmacology review must be included in the refresher training.
Certification application: High school diploma or GED: Required for EMT, AEMT and paramedic only. Provide proof of identity - State or federal photo I.D. (military ID, driver's license, passport). Provide proof of age - At least eighteen years of age. Variances to this age requirement will not be granted. Provide proof of EMS agency association - Active membership, paid or volunteer with: • Licensed aid or ambulance service; • Law enforcement agency; • Business with organized industrial safety team; • Senior EMS instructors or training coordinators, teaching at department-approved EMS training programs, who are unable to be associated with approved agencies above. Recommendation of county medical program director - Required. MPD must sign application. Background check - required. May include requirement for fingerprint card and FBI background check.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-141, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-141, filed 4/5/00, effective 5/6/00.]

WAC 246-976-142 To obtain reciprocal (out-of-state) EMS certification, based on a current out-of-state or national EMS certification approved by the department. To apply for certification, an applicant must submit to the department:

(1) A completed certification application on forms provided by the department; and

(2) Proof of meeting the requirements identified in Table A of this section.

Table A
Reciprocity—Out-of-State Applicants Seeking EMS Certification

REQUIREMENTS
EMS educational program: EMS courses conducted according to the U.S. Department of Transportation, national EMS training course standards. After June 30, 1996, paramedic training program must be accredited by a national accrediting organization approved by the department.
Additional education: Provide proof of a department-approved four-hour infectious disease course or a seven-hour HIV/AIDS course as required by chapter 70.24 RCW.
Current credential: Provide proof of valid EMS certification from another state or national certifying agency approved by the department.
Certification examination: Provide proof of a passing score on a department-approved certification examination for the level of certification. The score is valid for twelve months from the date of the examination. After twelve months, a passing score on a department-approved certification examination is required. Applicants will have three attempts within twelve months from the first examination date to pass the examination.
Certification application: High school diploma or GED: Required for EMT, AEMT and paramedic only. Provide proof of identity - State or federal photo I.D. (military ID, driver's license, passport).

REQUIREMENTS
Provide proof of age - At least eighteen years of age. Variances to this age requirement will not be granted. Provide proof of EMS agency association - Active membership, paid or volunteer with: • Licensed aid or ambulance service; • Law enforcement agency; • Business with organized industrial safety team; • Senior EMS instructors or training coordinators, teaching at department-approved EMS training programs, who are unable to be associated with approved agencies above. Recommendation of county medical program director - required. MPD must sign application. Background check - required. May include requirement for fingerprint card and FBI background check.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-142, filed 3/22/11, effective 5/15/11.]

WAC 246-976-143 To obtain EMS certification by challenging the educational requirements, based on possession of a current health care providers credential. To apply for certification, an applicant must submit to the department:

(1) A completed certification application on forms provided by the department; and

(2) Proof of meeting the requirements identified in Table A of this section.

Table A
Health Care Providers Seeking to Challenge the Educational Requirements for EMS Certification

REQUIREMENTS
Education: Course completion documents showing education equivalent to the knowledge and skills at the EMR, EMT or AEMT training level. Applicants seeking paramedic certification - Successful completion of a paramedic course through a training program accredited by a department-approved national accrediting organization.
Additional education: Provide proof of a department-approved four-hour infectious disease course or a seven-hour HIV/AIDS course as required by chapter 70.24 RCW.
Current credential: Provide proof of a valid health care provider credential.
Certification examination: A passing score on a department-approved certification examination. Applicants will have three attempts within twelve months from the first examination date to pass the examination. After twelve months, the applicant must complete an approved initial EMS course to reapply for certification.
Certification application: High school diploma or GED: Required for EMT, AEMT and paramedic only. Provide proof of identity - State or federal photo I.D. (military ID, driver's license, passport). Provide proof of age - At least eighteen years of age. Variances to this age requirement will not be granted. Provide proof of EMS agency association - Active membership, paid or volunteer with: • Licensed aid or ambulance service; • Law enforcement agency; • Business with organized industrial safety team. Recommendation of county medical program director - Required. MPD must sign application. Background check - required. May include requirement for fingerprint card and FBI background check.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-143, filed 3/22/11, effective 5/15/11.]

WAC 246-976-144 EMS certification. (1) Certification is effective on the date the department issues the certificate. Certifications must be renewed every three years. The expiration date is indicated on the certification card.

(2) The secretary may extend the certification period to accommodate the efficient processing of recertification applications. The expiration date will be indicated on the certification card issued by the department.

(3) Certification of AEMTs and paramedics is valid only:

(a) In the county or counties where recommended by the MPD and approved by the secretary;

(b) In other counties where formal EMS medical control agreements are in place; or

(c) In other counties when accompanying a patient in transit.

(d) While responding to other counties for mutual aid purposes, mass care, or other incidents. In these situations, EMS provider will provide patient care following the prehospital patient care protocols of their supervising MPD.

(4) A certified AEMT or paramedic may function at a lower certification level in counties other than those described in subsection (3)(a) through (c) of this section, with approval of that county's MPD.

(5) EMTs who have successfully completed IV therapy or supraglottic airway training may use those skills only when following approved county MPD protocols that permit EMTs with such training to perform those skills.

(6) When EMS personnel change or add membership with an EMS agency, or their contact information changes, they must notify the department within thirty days of the change. Changes submitted must be made on forms provided by the department.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-144, filed 3/22/11, effective 5/15/11.]

WAC 246-976-161 General education requirements for EMS provider recertification. (1) Education is required to recertify as an EMS provider.

(a) The EMS provider must complete the continuing medical education and examination (CME) method, identified in WAC 246-976-162 or the ongoing training and evaluation program (OTEP) method, identified in WAC 246-976-163 for each certification period.

(b) The EMS provider shall maintain records of successfully completed educational, practical skill evaluation and skill maintenance requirements.

(2) Education for recertification must be approved by the MPD. Educational and topic content requirements must include:

(a) Knowledge and skills found in instructor guidelines identified in WAC 246-976-023, appropriate to the level of certification being taught;

(b) Nationally recognized training programs for CPR, foreign body airway obstruction (FBAO), and defibrillation and patient care appro-

priate to the level of certification. Training must be at the health care provider level and meet Journal of American Medical Association (JAMA) standards; and

(c) Current county medical program director (MPD) protocols, regional patient care procedures, county operating procedures and state triage destination procedures.

(3) Nationally recognized training programs may be incorporated as part of content identified in subsection (2) of this subsection.

(4) Skill maintenance is a required educational component for recertification:

(a) For EMS providers completing the CME method the required skills are defined in WAC 246-976-162.

(b) For EMS providers completing the OTEP method the required skills are defined in WAC 246-976-163. These requirements may be obtained as part of an OTEP.

(5) Upon approval of the MPD, if an EMS provider is unable to complete the required endotracheal intubations as defined in WAC 246-976-162 or 246-976-163 the EMS provider may meet the endotracheal intubation requirements by completing an MPD and department-approved intensive airway management training program, covering all knowledge and skill aspects of emergency airway management.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-161, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71 and 18.73 RCW. WSR 04-08-103, § 246-976-161, filed 4/6/04, effective 5/7/04. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-161, filed 4/5/00, effective 5/6/00.]

WAC 246-976-162 The CME method of recertification. To complete the CME method of recertification, an EMS provider must:

(1) Complete and document the requirements, indicated in Table A of this section, appropriate to the level of certification for each certification period.

Table A
Education Requirements for Recertification

	EMR	EMT	AEMT	Paramedic
Annual Requirements				
Cardiovascular education and training	X	X	X	X
Spinal immobilization	X	X	X	X
Patient assessment	X	X	X	X
Certification Period Requirements				
Infectious disease	X	X	X	X
Trauma	X	X	X	X
Pharmacology		X	X	X
Other pediatric topics	X	X	X	X
Total minimum education hours per certification period:	15 hrs	30 hrs	60 hrs	150 hrs

"X" Indicates an individual must demonstrate knowledge and competency in the topic or skill.

(2) Complete and document the skills maintenance requirements, indicated in Table B of this section, appropriate to the level of certification.

Table B
Skills Maintenance Requirements for the CME Method

	EMR	EMT	AEMT	Paramedic
First Certification Period or Three Years				
□ **First Year**				
IV starts		EMT w/IV therapy skill 36	36	36
Endotracheal intubations (4 must be performed on humans)				12
Intraosseous infusion placement		EMT w/IV therapy skill X	X	X
□ **Second and Third Years**				
IV starts over the two-year period		EMT w/IV therapy skill 72	72	72
Endotracheal intubations over the two-year period (4 per year must be performed on humans)				24
Intraosseous infusion placement		EMT w/IV therapy skill X		
During the Certification Period				
Pediatric airway management				X
Supraglottic airway placement		EMT w/supraglottic airway skill X	X	X
Defibrillation	X	X	X	X
Later Certification Periods				
□ **Annual Requirements**				
IV starts		EMT w/IV therapy skill X	X	X
Endotracheal intubations (2 per year must be performed on humans)				4
Intraosseous infusion placement		EMT w/IV therapy skill X	X	X
□ **During the Certification Period**				
Pediatric airway management				X
Supraglottic airway placement		EMT w/supraglottic airway skill X	X	X
Defibrillation	X	X	X	X

"X" Indicates an individual must demonstrate proficiency of the skill to the satisfaction of the MPD.

(3) An EMS provider must successfully complete department-approved knowledge and practical skill examinations as identified in WAC 246-976-171.

(4) An EMS provider changing from the CME method to the OTEP method must meet all requirements of the OTEP method.

(5) Definitions of selected terms used in Tables A and B of this section:

(a) Cardiovascular education and training for adults, children, and infants includes:

(i) Nationally recognized training programs for CPR, foreign body airway obstruction (FBAO), and defibrillation and patient care appropriate to the level of certification;

(ii) The use of airway adjuncts appropriate to the level of certification;

(iii) The care of cardiac and stroke patients.

(b) Endotracheal intubation: Proficiency includes the verification of proper tube placement and continued placement of the endotracheal tube in the trachea through procedures identified in county MPD protocols.

(c) Infectious disease: Infectious disease training must meet the requirements of chapter 70.24 RCW.

(d) Intraosseous infusion: Proficiency in intraosseous line placement.

(e) IV starts: Proficiency in intravenous catheterization performed on sick, injured, or preoperative adult and pediatric patients. With written authorization of the MPD, IV starts may be performed on artificial training aids.

(f) Supraglottic airway placement: Proficiency includes the verification of tube placement and continued placement of the supraglottic airway, in a skill lab setting, through procedures identified in county MPD protocols.

(g) Other pediatric topics: This includes anatomy and physiology and medical problems including special needs patients appropriate to the level of certification.

(h) Patient assessment: This includes adult, pediatric and geriatric patients appropriate to the level of certification.

(i) Pharmacology: Pharmacology specific to the medications approved by the MPD (not required for EMRs).

(j) Proficiency: Ability to demonstrate and perform all aspects of a skill properly to the satisfaction of the MPD or delegate.

(k) Spinal immobilization and packaging: This includes adult, pediatric, and geriatric patients appropriate to the level of certification

(l) Trauma: For adult, pediatric, and geriatric patients appropriate to the level of certification.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-162, filed 3/22/11, effective 5/15/11.]

WAC 246-976-163 The OTEP method of recertification. (1) Ongoing training and evaluation programs (OTEP):

(a) Must provide knowledge and skill evaluations following completion of each topic presentation to determine student competence of topic content.

(i) Must record practical skill evaluations on skill evaluation forms from nationally recognized training programs, or on department-approved practical skill evaluation forms, for the level of certification being taught.

(ii) If an evaluation form is not provided, a skill evaluation form must be developed and approved by the MPD and the department to evaluate the skill;

(b) Must be conducted at least on a quarterly basis;

(c) Must be approved by the MPD and the department. Any additions or major changes to an approved OTEP requires documented approval from the county MPD and the department;

(d) Must be presented and evaluated by course personnel meeting the following qualifications:

(i) Evaluators must:

(A) Be a currently certified Washington EMS provider who has completed at least one certification cycle. Certification must be at or above the level of certification being evaluated;

(B) Complete an MPD approved evaluator's workshop, specific to the level of certification being evaluated, which teaches participants to properly evaluate practical skills using the skill evaluation forms identified in (a) of this subsection. Participants must demonstrate proficiency to successfully complete the workshop;

(C) Complete the evaluator application, DOH Form 530-012;

(I) Be approved by the county MPD and the department; and

(II) Submit the MPD approved EMS evaluator application to the department.

(D) Meet education and participation requirements as identified by the county medical program director;

(E) Be recommended for reapproval by the county medical program director upon EMS credential recertification.

(ii) Instructors must:

(A) Be a currently approved EMS evaluator at or above the level of certification being taught;

(B) Be approved by the county MPD to instruct and evaluate EMS topics;

(iii) Guest lecturers, when used, must have specific knowledge and experience in the skills of the prehospital emergency care field for the topic being presented and be approved by the county MPD to instruct EMS topics;

(e) May use online training to provide all or a portion of an OTEP when:

(i) Online training provides sufficient topic content to meet all annual and certification period requirements;

(ii) Each didactic training topic requires an online cognitive evaluation after the training. Successful completion of the topic evaluation is required to receive credit for the topic;

(iii) Instruction and demonstration of all practical skills are provided in person by an SEI or qualified EMS evaluator approved by the MPD to instruct the practical skills;

(iv) Each practical evaluation is completed and scored in the presence of a state approved EMS evaluator or SEI. Each evaluation must be successfully completed to receive credit for the practical skill.

(2) To complete the OTEP method of recertification, the EMS provider:

(a) Must complete a county MPD and department-approved OTEP that includes requirements indicated in Table A of this section, for the certification period, appropriate to the level of certification;

Table A
Education Requirements for Recertification

	EMR	EMT	AEMT	Paramedic
Annual Requirements				
Cardiovascular education and training	X	X	X	X
Spinal immobilization	X	X	X	X
Patient assessment	X	X	X	X
Certification Period Requirements				
Infectious disease	X	X	X	X
Trauma	X	X	X	X

Pharmacology		X	X	X
Other pediatric topics	X	X	X	X
* Total minimum education hours per certification period:	15 hrs	30 hrs	60 hrs	150 hrs

"X" Indicates an individual must demonstrate knowledge and competency in the topic or skill.
* Individuals obtaining education through the CME method must complete the total number of educational course hours indicated above. However, due to the competency-based nature of OTEP, fewer class hours may be needed to complete these requirements than the total course hours indicated above.

(b) Complete and document the skills maintenance requirements, indicated in Table B of this section, appropriate to the level of certification. Skill maintenance requirements may be obtained as part of the OTEP.

Table B
Skills Maintenance Requirements for the OTEP Method

	EMR	EMT	AEMT	Paramedic
First Certification Period or Three Years				
□ **First Year**				
IV starts		EMT w/IV therapy skill 12	12	12
Human endotracheal intubations				4
Intraosseous infusion placement		EMT w/IV therapy skill X	X	X
□ **Second and Third Years**				
IV starts over the two-year period		EMT w/IV therapy skill 12	24	24
Human endotracheal intubations over the two-year period				8
Intraosseous infusion placement		EMT w/IV therapy skill X	X	X
During the Certification Period				
Pediatric airway management		EMR & EMT X	X	X
Supraglottic airway placement		EMT w/supraglottic airway skill X	X	X
Defibrillation	X	X	X	X
Later Certification Periods				
□ **Annual Requirements**				
IV starts		EMT w/IV therapy skill X	X	X
Human endotracheal intubation				2
Intraosseous infusion placement		EMT w/IV therapy skill X	X	X
□ **During the Certification Period**				
Pediatric airway management		EMR & EMT X	X	X
Supraglottic airway placement		EMT w/supraglottic airway skill X	X	X
Defibrillation	X	X	X	X

"X" Indicates an individual must demonstrate proficiency of the skill to the satisfaction of the MPD.

(c) EMS providers using the OTEP method meet skill maintenance requirements by demonstrating proficiency in the application of those skills to the county MPD during the OTEP.

(d) Any EMS provider changing from the OTEP method to the CME method must meet all requirements of the CME method.

(3) Skill maintenance requirements for applicants requesting reciprocal certification:

(a) Reciprocity applicants credentialed less than three years must meet Washington state's skill maintenance requirements for the initial certification period identified above.

(b) Reciprocity applicants credentialed three years or more must meet Washington state's skill maintenance requirements for second and subsequent certification periods.

(c) The county MPD may evaluate an EMS provider's skills to determine proficiency in the application of those skills prior to recommending certification. The MPD may recommend that an EMS provider obtain specific training to become proficient in any skills deemed insufficient by the MPD or delegate.

(4) Definitions of selected terms used in Tables A and B of this section:

(a) Cardiovascular education and training for adults, children, and infants includes:

(i) Nationally recognized training programs for CPR, foreign body airway obstruction (FBAO), and defibrillation and patient care appropriate to the level of certification;

(ii) The use of airway adjuncts appropriate to the level of certification; and

(iii) The care of cardiac and stroke patients.

(b) Endotracheal intubation: Proficiency includes the verification of proper tube placement and continued placement of the endotracheal tube in the trachea through procedures identified in county MPD protocols.

(c) Infectious disease: Infectious disease training must meet the requirements of chapter 70.24 RCW.

(d) Intraosseous infusion: Proficiency in intraosseous line placement.

(e) IV starts: Proficiency in intravenous catheterization performed on sick, injured, or preoperative adult and pediatric patients. With written authorization of the MPD, IV starts may be performed on artificial training aids.

(f) Supraglottic airway placement: Proficiency includes the verification of tube placement and continued placement of the supraglottic airway, in a skill lab setting, through procedures identified in county MPD protocols.

(g) Other pediatric topics: This includes anatomy and physiology and medical problems including special needs patients appropriate to the level of certification.

(h) Patient assessment: This includes adult, pediatric, and geriatric patients appropriate to the level of certification.

(i) Pharmacology: Pharmacology specific to the medications approved by the MPD (not required for EMRs).

(j) Proficiency: Ability to demonstrate and perform all aspects of a skill properly to the satisfaction of the MPD or delegate.

(k) Spinal immobilization and packaging: This includes adult, pediatric, and geriatric patients appropriate to the level of certification.

(l) Trauma: For adult, pediatric, and geriatric patients appropriate to the level of certification.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-163, filed 3/22/11, effective 5/15/11.]

WAC 246-976-171 Recertification, reversion, reissuance, and reinstatement of certification. (1) To apply for recertification, an EMS provider must:

(a) Meet the requirements identified in Table A of this section for EMS providers completing the CME method; or

(b) Meet the requirements identified in Table B of this section for EMS providers completing the OTEP method; and

(c) Submit to the department a completed certification application on forms provided by the department.

Table A
EMS Providers Participating in the CME Method of Recertification

REQUIREMENTS
EMS Education Requirements: EMS providers participating in the CME method must provide proof of the following to the MPD or MPD delegate: • Successful completion of the educational requirements at the level of certification being sought, as specified in this chapter and identified in WAC 246-976-162, Table A; • Successful completion of skills maintenance required for the level of recertification being sought, as specified in this chapter and identified in WAC 246-976-162, Table B; • Passing department-approved practical skill certification examination for the level of certification being sought, within twelve months before submitting the application.
Recertification Examination: Provide proof of a passing score on the department-approved recertification examination for the level of recertification being sought. The EMS provider will have three attempts within twelve months of course completion to pass the examination. If the EMS provider is unsuccessful after three attempts, prior to subsequent attempts, refresher training must be completed as follows: • EMR twelve hours. • EMT twenty-four hours. • AEMT thirty hours - Pharmacology review must be included in the refresher training. • Paramedic forty-eight hours - Pharmacology review must be included in the refresher training.
Certification application: Provide proof of identity - State or federal photo I.D. (military ID, driver's license, passport). Provide proof of EMS agency association - Active membership, paid or volunteer with: • Licensed aid or ambulance service; • Law enforcement agency; • Business with organized industrial safety team; • Senior EMS instructors or training coordinators, teaching at department-approved EMS training programs, who are unable to be associated with approved agencies above. Recommendation of county medical program director. • The county MPD may require additional examinations to determine competency on department-approved MPD protocols prior to recommendation of recertification. • Required - MPD must sign application. Background check - may be required.

Table B
EMS Providers Participating in the OTEP Method of Recertification

REQUIREMENTS
EMS Education Requirements: EMS providers participating in the CME method must provide proof of the following to the MPD or MPD delegate: • Successful completion of the educational requirements at the level of certification being sought, as specified in this chapter and identified in WAC 246-976-163, Table A; • Successful completion of skills maintenance required for the level of certification being sought, as specified in this chapter and identified in WAC 246-976-163, Table B; • Successful completion of the OTEP knowledge and skill evaluations at the level of recertification being sought.
Recertification Examination: The evaluations required under this section fulfill the requirement of department-approved knowledge and practical skill recertification examinations.
Certification Application: Provide proof of identity - State or federal photo I.D. (military ID, driver's license, passport). Provide proof of EMS agency association - Active membership, paid or volunteer with: • Licensed aid or ambulance service; • Law enforcement agency; • Business with organized industrial safety team; • Senior EMS instructors or training coordinators, teaching at department-approved EMS training programs, who are unable to be associated with approved agencies above. Recommendation of county medical program director. • Obtain the county MPD recommendation for recertification and endorsement of EMT specialized training. • The county MPD may require additional examinations to determine competency on department-approved MPD protocols prior to recommendation of recertification. • Required - MPD must sign application. Background check - May be required.

(2) To voluntarily revert to a lower level of certification, an EMS provider must:

(a) For the CME method, complete the recertification education requirements identified in WAC 246-976-161 and 246-976-162, Tables A and B for the lower level of certification; or

(b) For the OTEP method, complete the recertification education requirements identified in WAC 246-976-161 and 246-976-163, Tables A and B at the lower level of certification; and

(c) Submit a completed certification application on forms provided by the department.

(3) An EMS provider may not provide EMS care with an expired certification.

(4) To apply for reissuance of an expired Washington state EMS certification:

(a) If a certification is expired for one year or less, the EMS provider must provide proof of the following to the county MPD or MPD delegate:

(i) Complete one additional year of annual recertification education requirements; and

(ii) For EMS providers completing the CME method, complete the requirements identified in Table A of this section; or

(iii) For EMS providers completing the OTEP method, complete the requirements identified in Table B of this section.

(b) If a certification is expired more than one year and less than two years, the EMS provider must provide proof of the following to the county MPD or MPD delegate:

(i) One additional year of annual recertification education requirements; and

(ii) Twenty-four hours of educational topics and hours specified by the department and the MPD; and

(iii) For EMS providers completing the CME method, complete the requirements identified in Table A of this section; or

(iv) For EMS providers completing OTEP, complete the requirements identified in Table B of this section.

(c) If a certification is expired for two years or longer, the EMS provider must provide proof of the following to the MPD or delegate:

(i) For nonparamedic EMS personnel:

(A) Complete a department-approved initial training program, and successfully complete department-approved knowledge and practical skill certification examinations;

(B) Complete the initial certification application requirements identified in WAC 246-976-141.

(ii) For paramedics whose certification has been expired between two and six years:

(A) Current status as a provider or instructor in the following: ACLS, PHTLS or BTLS, PALS or PEPPS, or state approved equivalent;

(B) Current status in health care provider level CPR;

(C) Completing a state approved forty-eight hour EMT-paramedic refresher training program or complete forty-eight hours of ALS training that consists of the following core content:

(I) Airway, breathing and cardiology - sixteen hours.

(II) Medical emergencies - eight hours.

(III) Trauma - six hours.

(IV) Obstetrics and pediatrics - sixteen hours.

(V) EMS operations - two hours.

(D) Successful completion of any additional required MPD and department-approved refresher training;

(E) Successful completion of MPD required clinical and field evaluations;

(F) Successful completion of department-approved knowledge and practical skill certification examinations;

(G) Complete the initial certification application requirements identified in WAC 246-976-141.

(d) A request for reissuance of a paramedic certification that has been expired greater than six years will be reviewed by the department to determine the disposition.

(5) Reinstatement of a suspended or revoked Washington state EMS certification.

(a) A person whose EMS certification is suspended or revoked may petition for reinstatement as provided in RCW 18.130.150;

(b) The petitioner must:

(i) Provide proof of completion of all requirements identified by the departmental disciplinary authority; and

(ii) Meet the reissuance requirements in this section.

(6) When EMS personnel change or add membership with an EMS agency, or their contact information changes, they must notify the department within thirty days of the change. Changes will be made on forms provided by the department.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-171, filed 3/22/11, effective 5/15/11. Statutory Authority: Chapters 18.71 and 18.73 RCW. WSR 04-08-103, § 246-976-171, filed 4/6/04, effective 5/7/04. Statutory Authority: Chapters 18.71,

18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-171, filed 4/5/00, effective 5/6/00.]

WAC 246-976-182 Authorized care—Scope of practice. (1) Certified EMS personnel are only authorized to provide patient care:

(a) When performing in a prehospital emergency setting or during interfacility ambulance transport; and

(b) When performing for a licensed EMS agency or an organization recognized by the secretary; and

(c) Within the scope of care that is:

(i) Included in the approved instructional guidelines/curriculum for the individual's level of certification; or

(ii) Included in approved specialized training; and

(iii) Included in state approved county MPD protocols.

(2) If protocols and regional patient care procedures do not provide off-line direction for the situation, the certified person in charge of the patient must consult with their online medical control as soon as possible. Medical control can only authorize a certified person to perform within their scope of practice.

(3) All prehospital providers must follow state approved triage procedures, regional patient care procedures and county MPD patient care protocols.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-182, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-182, filed 4/5/00, effective 5/6/00.]

WAC 246-976-191 Disciplinary actions. (1) The secretary is the disciplining authority under RCW 18.130.040 (2)(a).

(2) Modification, suspension, revocation, or denial of certification will be consistent with the requirements of the Administrative Procedure Act (chapter 34.05 RCW), the Uniform Disciplinary Act (chapter 18.130 RCW), and chapter 246-10 WAC.

(3) MPDs may perform counseling regarding the clinical practice of certified individuals.

(4) Before recommending disciplinary action, the MPD must initiate protocol and procedural counseling with the certified individual, consistent with department guidelines.

(5) The MPD may request the secretary to summarily suspend certification of an individual if the MPD believes that continued certification is an immediate and critical threat to public health and safety.

(6) The MPD may recommend denial or renewal of an individual's certification.

(7) As required by RCW 18.130.080, an employing or sponsoring agency is subject to the reporting requirements identified in chapter 246-16 WAC. An employing or sponsoring agency must report to the department the following:

(a) When the certified individual's services have been terminated or restricted based upon a final determination that the individual has either committed an act or acts that may constitute unprofessional conduct; or

(b) That the certified individual may not be able to practice his or her profession with reasonable skill and safety to consumers as a result of a mental or physical condition; or

(c) When a certified individual is disciplined by an employing or sponsoring agency for conduct or circumstances that would be unprofessional conduct under RCW 18.130.180 of the Uniform Disciplinary Act.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-191, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-191, filed 4/5/00, effective 5/6/00.]

LICENSURE AND VERIFICATION

WAC 246-976-260 Licenses required. (1) The secretary licenses ambulance and aid services and vehicles to provide service that is consistent with the state plan and approved regional plans.

(2) To become licensed as an ambulance or aid service, an applicant must submit:

(a) A completed application for licensure on forms provided by the department;

(b) Proof of the following insurance coverage:

(i) Motor vehicle liability coverage required in RCW 46.30.020 (ambulance and aid services only);

(ii) Professional and general liability coverage;

(c) A map of the proposed response area;

(d) The level of service to be provided: Basic life support (BLS), intermediate life support (ILS), or advanced life support (ALS) (paramedic); and the scheduled hours of operation. Minimum staffing required for each level is as follows:

(i) For aid service response:

(A) A BLS level service will provide care with at least one person qualified in advanced first aid;

(B) An ILS level service will provide care with at least one ILS technician (AEMT);

(C) An ALS level service will provide care with at least one paramedic.

(ii) For ambulance services:

(A) A BLS level service will provide care and transport with at least one emergency medical technician (EMT) and one person trained in advanced first aid;

(B) An ILS service will provide care and transport with at least one ILS technician and one EMT;

(C) An ALS service will provide care and transport with at least one paramedic and one EMT or higher level of EMS certification;

(D) Licensed services that provide critical care interfacility ambulance transports, must have sufficient medical personnel on each response to provide patient care specific to the transport;

(e) For licensed ambulance services, a written plan to continue patient transport if a vehicle becomes disabled, consistent with regional patient care procedures.

(3) To renew a license, submit application forms to the department at least thirty days before the expiration of the current license.

(4) Licensed ambulance and aid services must comply with department-approved prehospital triage procedures.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-260, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-260, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-260, filed 12/23/92, effective 1/23/93.]

WAC 246-976-270 Denial, suspension, revocation. (1) The secretary may suspend, modify, or revoke an agency's license or verification issued under this chapter. The secretary may deny licensure or verification to an applicant when it finds:

(a) Failure to comply with the requirements of chapters 18.71, 18.73, or 70.168 RCW, or other applicable laws or rules, or with this chapter;

(b) Failure to comply or ensure compliance with prehospital patient care protocols or regional patient care procedures;

(c) Failure to cooperate with the department in inspections or investigations;

(d) Failure to supply data as required in chapter 70.168 RCW and this chapter; or

(e) Failure to consistently meet trauma response times identified by the regional plan and approved by the department for trauma verified services.

(2) Modification, suspension, revocation, or denial of licensure or verification will be consistent with the requirements of the Administrative Procedure Act, chapter 34.05 RCW, and chapter 246-10 WAC. The secretary will not take action against a licensed, nonverified service under this section for providing emergency trauma care consistent with regional patient care procedures when the wait for the arrival of a verified service would place the life of the patient in jeopardy or seriously compromise patient outcome.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-270, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-270, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-270, filed 12/23/92, effective 1/23/93.]

WAC 246-976-290 Ground ambulance vehicle standards. (1) Essential equipment for patient and provider safety and comfort must be in good working order.

(2) All ambulance vehicles must be clearly identified as an EMS vehicle and display the agency identification by emblems and markings on the front, side, and rear of the vehicle. A current state ambulance credential must be prominently displayed in a clear plastic cover positioned high on the partition behind the driver's seat.

(3) Tires must be in good condition.

(4) The electrical system must meet the following requirements:

(a) Interior lighting in the driver compartment must be designed and located so that no glare is reflected from surrounding areas to the driver's eyes or line of vision from the instrument panel, switch panel, or other areas which may require illumination while the vehicle is in motion; and

(b) Interior lighting in the patient compartment must be provided throughout the compartment, and provide an intensity of twenty foot-candles at the level of the patient; and

(c) Exterior lights must be fully operational, and include body-mounted flood lights over the patient loading doors to provide loading visibility; and

(d) Emergency warning lights must be provided in accordance with RCW 46.37.380, as administered by the state commission on equipment.

(5) Windshield wipers and washers must be dual, electric, multi-speed, and functional at all times.

(6) Battery and generator system:

(a) The battery must be capable of sustaining all systems. It must be located in a ventilated area sealed off from the vehicle interior, and completely accessible for checking and removal;

(b) The generating system must be capable of supplying the maximum built-in DC electrical current requirements of the ambulance. If the electrical system uses fuses instead of circuit breakers, extra fuses must be provided.

(7) The ambulance must be equipped with:

(a) Seat belts that comply with Federal Motor Vehicle Safety Standards 207, 208, 209, and 210. Restraints must be provided in all seat positions in the vehicle, including the attendant station; and

(b) Mirrors on the left side and right side of the vehicle. The location of mounting must provide maximum rear vision from the driver's seated position; and

(c) One ABC two and one-half pound fire extinguisher.

(8) Ambulance body requirements:

(a) The length of the patient compartment must be at least one hundred twelve inches in length, measured from the partition to the inside edge of the rear loading doors; and

(b) The width of the patient compartment, after cabinet and cot installation, must provide at least nine inches of clear walkway between cots or the squad bench; and

(c) The height of the patient compartment must be at least fifty-three inches at the center of the patient area, measured from floor to ceiling, exclusive of cabinets or equipment; and

(d) There must be secondary egress from the vehicle; and

(e) Back doors must open in a manner to increase the width for loading patients without blocking existing working lights of the vehicle; and

(f) The floor at the lowest level permitted by clearances. It must be flat and unencumbered in the access and work area, with no voids or pockets in the floor to side wall areas where water or moisture can become trapped to cause rusting or unsanitary conditions; and

(g) Floor covering applied to the top side of the floor surface. It must withstand washing with soap and water or disinfectant without damage to the surface. All joints in the floor covering must have minimal void between matching edges, cemented with a suitable water-proof and chemical-proof cement to eliminate the possibility of joints loosening or lifting; and

(h) The finish of the entire patient compartment must be impervious to soap and water and disinfectants to permit washing and sanitizing; and

(i) Exterior surfaces must be smooth, with appurtenances kept to a minimum; and

(j) Restraints must be provided for all litters. If the litter is floor supported on its own support wheels, a means must be provided to

secure it in position. These restraints must permit quick attachment and detachment for quick transfer of patient.

(9) Vehicle brakes, regular and special electrical equipment, heating and cooling units, safety belts, and window glass, must be functional at all times.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-290, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-290, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-290, filed 12/23/92, effective 1/23/93.]

WAC 246-976-300 Ground ambulance and aid service—Equipment. Ground ambulance and aid services must provide equipment listed in Table A of this section on each licensed vehicle, when available for service.

Note: "asst" means assortment	AMBULANCE	AID VEHICLE
TABLE A: EQUIPMENT		
AIRWAY MANAGEMENT		
Airway Adjuncts		
Oral airway adult and pediatric	asst	asst
Suction		
Portable	1	1
Vehicle mounted and powered, providing: Minimum of 30 L/min. & vacuum > 300 mm Hg	1	0
Tubing, suction	1	1
Bulb syringe, pediatric	1	1
Rigid suction tips	2	1
Catheters as required by local protocol		
Water-soluble lubricant	1	1
Oxygen delivery system built in	1	0
3000 L Oxygen supply, with regulator, 500 PSI minimum, or equivalent liquid oxygen system	1	0
300 L Oxygen supply, with regulator, 500 PSI minimum, or equivalent liquid oxygen system	2	1
Cannula, nasal, adult	4	2
O_2 mask, nonrebreather, adult	4	2
O_2 mask, nonrebreather, pediatric	2	1
BVM, with O_2 reservoir		
Adult, pediatric, infant	1 ea	1 ea
PATIENT ASSESSMENT AND CARE		
Assessment		
Sphygmomanometer		
Adult, large	1	1
Adult, regular	1	1
Pediatric	1	1
Stethoscope, adult	1	1
Thermometer, per county protocol	1	0

Note: "asst" means assortment	AMBULANCE	AID VEHICLE
Flashlight, w/spare or rechargeable batteries & bulb	1	1
Defibrillation capability appropriate to the level of personnel	1	1
Personal infection control and protective equipment as required by the department of labor and industries		
Length based tool for estimating pediatric medication and equipment sizes	1	1
TRAUMA EMERGENCIES		
Triage identification for 12 patients per county protocol	Yes	Yes
Wound care		
Dressing, sterile	asst	asst
Dressing, sterile, trauma	2	2
Roller gauze bandage	asst	asst
Medical tape	asst	asst
Self adhesive bandage strips	asst	asst
Cold packs	4	2
Occlusive dressings	2	2
Scissors, bandage	1	1
Irrigation solution	2	1
Splinting		
Backboard with straps	2	1
Head immobilization equipment	1	1
Pediatric immobilization device	1	1
Extrication collars, rigid		
Adult (small, medium, large)	asst	asst
Pediatric or functionally equivalent sizes	asst	asst
Immobilizer, cervical/thoracic, adult	1	0
Splint, traction, adult w/straps	1	0
Splint, traction, pediatric, w/straps	1	0
Splint, adult (arm and leg)	2 ea	1 ea
Splint, pediatric (arm and leg)	1 ea	1 ea
General		
Litter, wheeled, collapsible, with a functional restraint system per the manufacturer	1	0
Pillows, plastic covered or disposable	2	0
Pillow case, cloth or disposable	4	0
Sheets, cloth or disposable	4	2
Blankets	2	2
Towels, cloth or disposable 12" x 23" minimum	4	2
Emesis collection device	1	1
Urinal	1	0
Bed pan	1	0
OB kit	1	1
Epinephrine and supplies appropriate for level of certification per MPD protocols		
Adult	1	1
Pediatric	1	1
Storage and handling of pharmaceuticals in ambulances and aid vehicles must be in compliance with the manufacturers' recommendations		

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-300, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-300, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-300, filed 12/23/92, effective 1/23/93.]

WAC 246-976-310 Ground ambulance and aid service—Communications equipment. (1) Licensed services must provide each licensed ambulance and aid vehicle with communication equipment which:

(a) Is consistent with state and regional plans;

(b) Is in good working order;

(c) Allows direct two-way communication between the vehicle and its dispatch control point; and

(d) Allows communication with medical control.

(2) If cellular telephones are used, there must also be another method of radio contact with dispatch and medical control for use when cellular service is unavailable.

(3) Licensed ambulance services must provide each licensed ambulance with communication equipment which:

(a) Allows direct two-way communication with medical control and all hospitals in the service area of the vehicle, from both the driver's and patient's compartment; and

(b) Incorporates appropriate encoding and selective signaling devices.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-310, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-310, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-310, filed 12/23/92, effective 1/23/93.]

WAC 246-976-320 Air ambulance services. The purpose of this rule is to ensure the consistent quality of medical care delivered by air ambulance services in the state of Washington.

(1) An air ambulance service operating in the state of Washington must:

(a) Be licensed by the department in compliance with this section unless an exception in RCW 18.73.130 applies;

(b) Comply with all regulations and standards in this chapter pertaining to licensed and verified ambulance services and vehicles, except that WAC 246-976-290 and 246-976-300 are replaced for air ambulance services by subsections (7) and (8) of this section; and

(c) Comply with the standards in this section for all types of transports, including interfacility and prehospital transports.

(2) An air ambulance service applying for initial or renewal licensure must:

(a) Provide a completed application for licensure on forms provided by the department;

(b) Provide copies of the following current and valid documentation issued by the Federal Aviation Administration (FAA):

(i) Air Taxi Registration (OST Form 4507) showing the effective date of FAA registration and exemption under 14 C.F.R. 298;

(ii) Air carrier certificate authorizing common carriage under 14 C.F.R. 135, including Operations Specifications (FAA form 8430-18) authorizing aeromedical helicopter or fixed-wing air ambulance operations as applicable;

(iii) Certificate of Registration (AC form 8050-3) for each air ambulance operated; and

(iv) Standard Airworthiness Certificate (FAA form 8100-2) for each air ambulance operated;

(c) Provide a certificate of insurance establishing current and valid public and passenger liability insurance coverage for the air ambulance service;

(d) Provide a certificate of insurance establishing current and valid professional and general liability insurance coverage for the air ambulance service; and

(e) Provide proof of the air ambulance service's current accreditation status and a copy of the current accreditation report by a nationally recognized and department approved air ambulance accreditation entity that demonstrates that the air ambulance service meets the standards in this section. Failure to produce the accreditation report and supporting documentation to the department may be grounds for denial, suspension, or revocation of an ambulance license.

(3) An air ambulance service requesting initial licensure or renewal of licensure:

(a) That is ineligible to attain accreditation because it lacks a history of operation, must meet the standards in this section and provide proof that the air ambulance service is pursuing accreditation review with an accreditation entity approved by the department. A provisional license may be granted for no longer than two years at which time the service must provide documentation from a department approved accreditation entity that it meets the standards in this section.

(b) That has been unable to obtain accreditation may apply for a waiver of the full accreditation requirement if the air ambulance service meets all components of accreditation that are consistent with the standards in this section other than criteria related to the Federal Aviation Agency or Airline Deregulation Act regulated activities. The applicant must supply a copy of the accreditation report and supporting documentation to the department to show that it meets the standards in this section.

(4) To meet the minimum standards for medical oversight and patient care protocols an air ambulance service must:

(a) Have a physician director. The physician director must be:

(i) The department-certified medical program director (MPD) of the county where the air ambulance service declares its primary base of operation or a physician delegate of that county's MPD, as provided in WAC 246-976-920(4);

(ii) Licensed to practice in the state of Washington and in current good standing; and

(iii) Able to provide proof of educational experience consistent with the mission statement and scope of care provided by the air ambulance service;

(b) Ensure that all medical team members hold current and valid Washington state health care profession licenses;

(c) Ensure that all prehospital personnel used by the air ambulance service per subsection (5) of this section hold current and valid Washington state certifications as defined in WAC 246-976-010 and in accordance with RCW 18.71.200 and 18.71.205. Certified prehospital personnel must comply with department approved, MPD patient care protocols;

(d) Have a quality management program; and

(e) Ensure data related to patient care and transport services is collected and reviewed regularly and protected health care information is handled according to state and federal law and regulations.

(5) An air ambulance service must meet the following minimum standards for staffing of air ambulances:

(a) All medical personnel on each transport must have education, experience, qualifications, and credentials consistent with the mission statement and scope of care provided by the air ambulance service;

(b) Each critical care transport (CCT) is staffed by a medical team of at least two individuals with at least the following qualifications and licensure:

(i) One paramedic or registered nurse trained in prehospital emergency care; and

(ii) One other person who must be a registered nurse, respiratory therapist, paramedic, advanced EMT, EMT, or other appropriate specialist as appointed by the physician director;

(c) Each advanced life support (ALS) transport is staffed by a medical team of at least two individuals with at least the following qualifications and licensure:

(i) One paramedic; and

(ii) One other person, who must be a paramedic, advanced EMT, EMT, or other appropriate specialist as appointed by the physician director; and

(d) Each basic life support (BLS) transport is staffed by a medical team of at least two individuals in accordance with ambulance personnel requirements listed in RCW 18.73.150.

(6) An air ambulance service must meet the following minimum standards for training of air ambulance medical personnel:

(a) Establish and maintain a structured training program. If prehospital personnel are used by the air ambulance service, the training program must also meet requirements as defined in chapter 246-976 WAC;

(b) Create and maintain a file for each medical team member containing documentation of the personnel member's qualifications including, as applicable, licenses, certifications, and training records; and

(c) Ensure that each medical team member completes training in the following subjects before serving on a transport:

(i) Aviation terminology;

(ii) Altitude physiology and stressors of flight;

(iii) Patient loading and unloading;

(iv) Safety in and around the aircraft;

(v) In-flight communications;

(vi) Use, removal, replacement, and storage of the medical equipment installed on the aircraft;

(vii) In-flight emergency procedures;

(viii) Emergency landing and evacuation procedures; and

(ix) Policies and procedures for the air ambulance service, including policies to address altitude limitations.

(7) An air ambulance service must meet the following minimum standards for aircraft configuration and equipment to safely and effectively treat ill and injured patients on air ambulance transports and that include:

(a) A climate control system to prevent temperature extremes that would adversely affect patient care;

(b) Interior lighting that allows for patient care and monitoring without interfering with the pilot's vision;

(c) At least one outlet per patient and electric current which is capable of operating all electrically powered medical equipment unless battery power is available that exceeds the flight time for the transport;

(d) A back-up source of electric current or batteries capable of operating all electrically powered life support equipment for at least a minimum of one hour;

(e) An entry that allows for patient loading and unloading without rotating a patient and stretcher more than thirty degrees about the longitudinal (roll) axis or forty-five degrees about the lateral (pitch) axis and without compromising the operation of monitoring systems, intravenous lines, or manual or mechanical ventilation;

(f) Adequate space that allows each medical team member sufficient access to each patient to begin and maintain treatment modalities, including complete access to the patient's head and upper body for effective airway management;

(g) Adequate placement of stretcher and medical equipment that does not impede rapid egress by personnel or patient from the aircraft; and

(h) A communications system that is capable of air to ground communication with, ground fire and EMS services, public safety vehicles, hospitals, medical control, and communication centers and that allows the flight crew and medical team members to communicate with each other during the transport.

(8) An air ambulance service must meet the following minimum standards for medical equipment aboard air ambulances:

(a) Maintain and provide a minimum of the following equipment, supplies, and medications consistent with the mission statement and scope of care provided on transports. All equipment, supplies, and medications must be approved for use by the MPD and physician director.

(i) Minimum equipment available for each basic life support (BLS) transport must include:

(A) Oral/nasal pharyngeal airway;

(B) Nonrebreather oxygen mask;

(C) Bag valve mask;

(D) Pulse oximeter;

(E) Oxygen source;

(F) Automated external defibrillator;

(G) Noninvasive vital sign measurement;

(H) Glucometer;

(I) Equipment for control of bleeding to include tourniquets;

(J) Infection control;

(K) Medications consistent with scope of practice and care required for the transport type;

(L) Spinal motion restriction; and

(M) Neonatal and pediatric equipment sufficient for all aspects of prehospital and interfacility specialized care, if the air ambulance service provides transport to this population.

(ii) Minimum equipment available for each advanced life support (ALS) transport must include:

(A) All BLS equipment required in (a)(i) of this subsection; and

(B) Equipment for endotracheal intubation to include alternative airways such as supraglottic airways;

(C) Equipment for needle thoracostomy;

(D) Noninvasive carbon dioxide (CO_2) monitoring with numerical and waveform capability;

(E) Equipment to establish and maintain a peripheral IV;

(F) Equipment to establish and maintain an intraosseous infusion;

(G) Ventilator;

(H) Equipment to provide continuous positive airway pressure (CPAP);

(I) Cardiac monitor capable of performing twelve lead ECG, defibrillation, cardioversion, and external pacing;

(J) Medications consistent with scope of practice and care required for the transport type; and

(K) Neonatal and pediatric equipment sufficient for all aspects of prehospital and interfacility specialized care, if the air ambulance service provides transport to this population.

(iii) Minimum equipment available for each critical care transport (CCT) must include:

(A) All BLS equipment required in (a)(i) of this subsection; and

(B) All ALS equipment required in (a)(ii) of this subsection; and

(C) Multimodality ventilators capable of invasive ventilation appropriate to all age groups transported;

(D) Invasive hemodynamic monitoring, transvenous pacemakers, central venous pressure and arterial pressure;

(E) Medications consistent with scope of practice and care required for the transport type; and

(F) Neonatal and pediatric equipment sufficient for all aspects of prehospital and interfacility specialized care, if the air ambulance service provides transport to this population.

(iv) Ensure that during a transport, the air ambulance has the equipment and supplies necessary to provide an appropriate level of medical care for the patient and to protect the health and safety of the personnel on the transport;

(v) Maintain and provide upon request equipment, supply and medication inventories that document what is included for each type of transport; and

(vi) Ensure the equipment and supplies on an air ambulance are secured, stored, and maintained in a manner that prevents hazards to personnel and patients.

[Statutory Authority: RCW 70.168.050 and Eagle Air Med Corp. v. Colorado Board of Health, 570 F. Supp. 2d 1289. WSR 17-07-059, § 246-976-320, filed 3/13/17, effective 4/13/17. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-320, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 18.73.140. WSR 00-22-124, § 246-976-320, filed 11/1/00, effective 12/2/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-320, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-320, filed 12/23/92, effective 1/23/93.]

WAC 246-976-330 Ambulance and aid services—Record requirements. (1) Each ambulance and aid service must maintain a record of, and submit to the department, the following information on request:

(a) Current certification levels of all personnel;

(b) Any changes in staff affiliation with the ambulance and aid service to include new employees or employee severance; and

(c) Make, model, and license number of all EMS response vehicles.

(2) The certified EMS provider in charge of patient care must provide the following information to the receiving facility staff:

(a) At the time of arrival at the receiving facility, a minimum of a brief written or electronic patient report including agency name, EMS personnel, and:

(i) Date and time of the medical emergency;

(ii) Time of onset of symptoms;

(iii) Patient vital signs including serial vital signs where applicable;

(iv) Patient assessment findings;

(v) Procedures and therapies provided by EMS personnel;

(vi) Any changes in patient condition while in the care of the EMS personnel;

(vii) Mechanism of injury or type of illness.

(b) Within twenty-four hours of arrival, a complete written or electronic patient care report that includes at a minimum:

(i) Names and certification levels of all personnel providing patient care;

(ii) Date and time of medical emergency;

(iii) Age of patient;

(iv) Applicable components of system response time;

(v) Patient vital signs, including serial vital signs if applicable;

(vi) Patient assessment findings;

(vii) Procedures performed and therapies provided to the patient; this includes the times each procedure or therapy was provided;

(viii) Patient response to procedures and therapies while in the care of the EMS provider;

(ix) Mechanism of injury or type of illness;

(x) Patient destination.

(c) For trauma patients, all other data points identified in WAC 246-976-430 for inclusion in the trauma registry must be submitted within ten days of transporting the patient to the trauma center.

(3) Licensed services must make all patient care records available for inspection and duplication upon request of the county MPD or the department.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-330, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 70.168.060 and 70.168.090. WSR 02-02-077, § 246-976-330, filed 12/31/01, effective 1/31/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-330, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-330, filed 12/23/92, effective 1/23/93.]

WAC 246-976-340 Ambulance and aid services——Inspections and investigations. (1) The department may conduct periodic, unannounced inspections of licensed ambulances and aid vehicles and services.

(2) If the service is also verified in accordance with WAC 246-976-390, the department will include a review for compliance with verification standards as part of the inspections described in this section.

(3) Licensed services shall make available to the department and provide copies of any printed or written materials relevant to the inspection, verification review, or investigative process in a timely manner.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-340, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-340, filed 12/23/92, effective 1/23/93.]

WAC 246-976-390 Trauma verification of prehospital EMS services. (1) The secretary verifies prehospital EMS services. Verification is a higher form of licensure that requires twenty-four-hour, seven day a week compliance with the standards outlined in chapter 70.168 RCW and this chapter. Verification will expire with the prehospital EMS service's period of licensure.

(2) To qualify for trauma verification, an agency must be a licensed ambulance or aid service as specified in WAC 246-976-260.

(3) The following EMS services may be verified:

(a) Aid service: Basic, intermediate (AEMT), and advanced (paramedic) life support;

(b) Ground ambulance service: Basic, intermediate (AEMT), and advanced (paramedic) life support;

(c) Air ambulance service.

(4) Personnel requirements:

(a) Verified aid services must provide personnel on each trauma response including:

(i) Basic life support: At least one individual who is an EMR or above;

(ii) Intermediate life support: At least one AEMT;

(iii) Advanced life support - Pramedic: At least one paramedic;

(b) Verified ambulance services must provide personnel on each trauma response including:

(i) Basic life support: At least two certified individuals - one EMT plus one EMR;

(ii) Intermediate life support: One AEMT, plus one EMT;

(iii) Advanced life support - Paramedic: At least two certified individuals - One paramedic and one EMT;

(c) Verified air ambulance services must provide personnel as identified in WAC 246-976-320.

(5) Equipment requirements:

(a) Verified BLS vehicles must carry equipment identified in WAC 246-976-300, Table A;

(b) Verified ILS and paramedic vehicles must provide equipment identified in Table A of this section, in addition to meeting the requirements of WAC 246-976-300;

(c) Verified air ambulance services must meet patient care equipment requirements described in WAC 246-976-320.

TABLE A: EQUIPMENT FOR VERIFIED TRAUMA SERVICES (NOTE: "ASST" MEANS ASSORTMENTS. "X" INDICATES REQUIRED.)	AMBULANCE		AID VEHICLE	
	PAR	ILS	PAR	ILS
AIRWAY MANAGEMENT				
Airway adjuncts				
Adjunctive airways, assorted per protocol	X	X	X	X
Laryngoscope handle, spare batteries	1	1	1	1
Adult blades, set	1	1	1	1
Pediatric blades, straight (0, 1, 2)	1 ea	1 ea	1 ea	1 ea
Pediatric blades, curved (2)	1 ea	1 ea	1 ea	1 ea
McGill forceps, adult & pediatric	1	1	1	1
ET tubes, adult and pediatric	asst	0	asst	0
Supraglottic airways per MPD protocol	X	X	X	X
End-tidal CO_2 detector	1 ea	1 ea	1 ea	1 ea
Oxygen saturation monitor	1 ea	1 ea	1 ea	1 ea
TRAUMA EMERGENCIES				
IV access				
Administration sets and intravenous fluids per protocol:				
Adult	4	4	2	2
Pediatric volume control device	2	2	1	1
Catheters, intravenous (14-24 ga)	asst	asst	asst	asst
Needles				
Hypodermic	asst	asst	asst	asst
Intraosseous, per protocol	2	2	1	1
Sharps container	1	1	1	1
Syringes	asst	asst	asst	asst
Glucose measuring supplies	Yes	Yes	Yes	Yes
Pressure infusion device	1	1		
Length based tool for estimating pediatric medication and equipment sizes	1	1	1	1
Medications according to local patient care protocols				

(6) Aid service response time requirements: Verified aid services must meet the following minimum agency response times as defined by the department and identified in the regional plan:

(a) To urban response areas: Eight minutes or less, eighty percent of the time;

(b) To suburban response areas: Fifteen minutes or less, eighty percent of the time;

(c) To rural response areas: Forty-five minutes or less, eighty percent of the time;

(d) To wilderness response areas: As soon as possible.

(7) Ground ambulance service response time requirements: Verified ground ambulance services must meet the following minimum agency response times for all EMS and trauma responses to response areas as defined by the department and identified in the regional plan:

(a) To urban response areas: Ten minutes or less, eighty percent of the time;

(b) To suburban response areas: Twenty minutes or less, eighty percent of the time;

(c) To rural response areas: Forty-five minutes or less, eighty percent of the time;

(d) To wilderness response areas: As soon as possible.

(8) Verified air ambulance services must meet minimum agency response times as identified in the state plan.

(9) Verified ambulance and aid services must comply with the approved prehospital trauma triage procedures defined in WAC 246-976-010.

(10) The department will:

(a) Identify minimum and maximum numbers of prehospital services, based on:

(i) The approved regional EMS and trauma plans, including: Distribution and level of service identified for each response area; and

(ii) The Washington state EMS and trauma plan;

(b) With the advice of the steering committee, consider all available data in reviewing response time standards for verified prehospital trauma services at least biennially;

(c) Administer the BLS/ILS/ALS verification application and evaluation process;

(d) Approve an applicant to provide verified prehospital trauma care, based on satisfactory evaluations as described in this section;

(e) Obtain comments from the regional council as to whether the application(s) appears to be consistent with the approved regional plan;

(f) Provide written notification to the applicant(s) of the final decision in the verification award;

(g) Notify the regional council and the MPD in writing of the name, location, and level of verified services;

(h) Approve renewal of a verified service upon reapplication, if the service continues to meet standards established in this chapter and verification remains consistent with the regional plan.

(11) The department may:

(a) Conduct a preverification site visit; and

(b) Grant a provisional verification not to exceed one hundred twenty days. The secretary may withdraw the provisional verification status if provisions of the service's proposal are not implemented within the one hundred twenty-day period, or as otherwise provided in chapter 70.168 RCW and this chapter.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-390, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 18.73.140. WSR 00-22-124, § 246-976-390, filed 11/1/00, effective 12/2/00. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-390, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-390, filed 12/23/92, effective 1/23/93.]

WAC 246-976-395 To apply for initial verification or to change verification status as a prehospital EMS service. (1) To select verified prehospital EMS services, the department will:

(a) Provide a description of the documents an applicant must submit to demonstrate that it meets the standards as identified in chapter 70.168 RCW and WAC 246-976-390;

(b) Conduct a preverification on-site review for:

(i) All ALS ambulance service applications;

(ii) All ILS ambulance service applications; and

(iii) All BLS ambulance applications if and when there is any question of duplication of services or lack of coordination of prehospital services within the region;

(c) Request comments from the region in which a verification application is received, to be used in the department's review;

(d) Apply the department's evaluation criteria; and

(e) Apply the department's decision criteria.

(2) To apply for verification you must:

(a) Be a licensed prehospital EMS ambulance or aid service as specified in WAC 246-976-260;

(b) Submit a completed application:

(i) If you are applying for verification in more than one region, you must submit a separate application for each region;

(ii) You must apply for verification when you are:

(A) An agency that responds to 9-1-1 emergencies as part of its role in the EMS system;

(B) A new business or legal entity that is formed through consolidation of existing services or a newly formed EMS agency;

(C) An EMS agency that seeks to provide prehospital emergency response in a region in which it previously has not been operating; or

(D) A service that is changing, or has changed its type of verification or its verification status.

(3) The department will evaluate each prehospital EMS service applicant on a point system. In the event there are two or more applicants, the secretary will verify the most qualified applicant. The decision to verify will be based on at least the following:

(a) Total evaluation points received on all completed applications:

(i) Applicants must receive a minimum of one hundred fifty points of the total two hundred points possible from the overall evaluation scoring tool to qualify for verification.

(ii) Applicants must receive a minimum of thirty points in the evaluation of its clinical and equipment capabilities section of the evaluation scoring tool to qualify for verification;

(b) Recommendations from the on-site review team, if applicable;

(c) Comment from the regional council(s);

(d) Dispatch plan;

(e) Response plan;

(f) Level of service;

(g) Type of transport, if applicable;

(h) Tiered response and rendezvous plan;

(i) Back-up plan to respond;

(j) Interagency relations;

(k) How the applicant's proposal avoids unnecessary duplication of resources or services;

(l) How the applicant's service is consistent with and will meet the specific needs as outlined in their approved regional EMS and trauma plan including the patient care procedures;

(m) Ability to meet vehicle requirements;

(n) Ability to meet staffing requirements;

(o) How certified EMS personnel have been, or will be, trained so they have the necessary understanding of department-approved MPD protocols, and their obligation to comply with the MPD protocols;

(p) Agreement to participate in the department-approved regional quality improvement program.

(4) Regional EMS and trauma care councils may provide comments to the department regarding the verification application, including written statements on the following if applicable:

(a) Compliance with the department-approved minimum and maximum number of verified trauma services for the level of verification being sought by the applicant;

(b) How the proposed service will impact care in the region to include discussion on:

(i) Clinical care;

(ii) Response time to prehospital incidents;

(iii) Resource availability; and

(iv) Unserved or under served trauma response areas;

(c) How the applicant's proposed service will impact existing verified services in the region.

(5) Regional EMS/TC councils will solicit and consider input from local EMS/TC councils where local councils exist.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-395, filed 3/22/11, effective 5/15/11.]

WAC 246-976-400 Verification—Noncompliance with standards. If the department finds that a verified prehospital trauma care service is out of compliance with verification standards:

(1) The department shall promptly notify in writing: The service, the MPD, and the local and regional EMS/TC councils.

(2) Within thirty days of the department's notification, the service must submit a corrective plan to the department, the MPD, and the local and regional councils outlining proposed action to return to compliance.

(3) If the service is either unable or unwilling to comply with the verification standards, under the provisions of chapter 34.05 RCW, the secretary may suspend or revoke the verification. The department shall promptly notify the local and regional councils and the MPD of any revocation or suspension of verification.

If the MPD, the local council, or regional council receives information that a service is out of compliance with the regional plan, they may forward their recommendations for corrections to the department.

(4) The department will review the plan within thirty days, including consideration of any recommendations from the MPD, local council, and regional council. The department will notify the service whether the plan is accepted or rejected.

(5) The department will monitor the service's progress in fulfilling the terms of the approved plan.

(6) A verified prehospital service that is not in compliance with verification standards will not receive a participation grant.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-400, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-400, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-400, filed 12/23/92, effective 1/23/93.]

TRAUMA REGISTRY

WAC 246-976-420 Trauma registry—Department responsibilities. (1) Purpose: The department maintains a trauma registry, as required by RCW 70.168.060 and 70.168.090. The purpose of this registry is to:

(a) Provide data for trauma surveillance, analysis, and prevention programs;

(b) Monitor and evaluate the outcome of care of trauma patients, in support of statewide and regional quality assurance and system evaluation activities;

(c) Assess compliance with state standards for trauma care;

(d) Provide information for resource planning, system design and management; and

(e) Provide a resource for research and education.

(2) Confidentiality: RCW 70.168.090, 70.41.200, and chapter 42.56 RCW apply to trauma registry data and patient quality assurance proceedings, records, and reports developed pursuant to RCW 70.168.090. Data elements related to the identification of individual patient's, provider's, and facility's care outcomes shall be confidential, shall be exempt from chapter 42.56 RCW, and shall not be subject to discovery by subpoena or admissible as evidence. Patient care quality assurance proceedings, records, and reports developed pursuant to RCW 70.168.090 are confidential, exempt from chapter 42.56 RCW, and are not subject to discovery by subpoena or admissible as evidence.

(a) The department may release confidential information from the trauma registry in compliance with applicable laws and regulations. No other person may release confidential information from the trauma registry without express written permission from the department.

(b) The department may approve requests for trauma registry data reports from qualified agencies or individuals, consistent with applicable statutes and rules. The department may charge reasonable costs associated with customized reports, prepared in response to such requests.

(c) The department has established criteria defining situations in which additional trauma registry information is confidential, in order to protect confidentiality for patients, providers, and facilities.

(d) Subsection (2)(a) through (d) of this section does not limit access to confidential data by approved regional quality assurance and improvement programs established under chapter 70.168 and described in WAC 246-976-910.

(3) Inclusion criteria: The department establishes inclusion criteria to identify those injured patients whom trauma services must report to the trauma registry.

(a) The criteria includes all patients who were discharged with International Classification of Diseases (ICD) diagnosis codes for injuries, drowning, burns, asphyxiation, or electrocution per the department's specifications and one of the following additional criteria:

(i) The trauma service trauma resuscitation team (full or modified) was activated for the patient;

(ii) The patient was dead on arrival at the trauma service;

(iii) The patient was dead at discharge from the trauma service;

(iv) The patient was transferred by ambulance into the trauma service from another facility;

(v) The patient was transferred by ambulance out of the trauma service to another acute care facility;

(vi) The patient was an adult patient (age fifteen or greater) and was admitted to the trauma service and had a length of stay of more than twenty-four hours;

(vii) The patient was a pediatric patient (ages under fifteen years) and was admitted to the trauma service, regardless of length of stay; or

(viii) The patient was an injured patient flown from the scene.

(b) For all licensed rehabilitation services, the criteria includes all patients who received rehabilitative care for acute injury or illness.

(4) Other data: The department and regional quality assurance programs may request data from medical examiners and coroners to be used in support of the trauma registry.

(5) Data submission: The department establishes procedures and format for trauma services to submit data electronically. These will include a mechanism for the reporting agency to check data for validity and completeness before data is sent to the trauma registry.

(6) Data quality: The department establishes mechanisms to evaluate the quality of trauma registry data. These mechanisms will include:

(a) Detailed protocols for quality control, consistent with the department's most current data quality guidelines.

(b) Validity studies to assess the timeliness, completeness and accuracy of case identification and data collection.

(7) Trauma registry reports:

(a) Annually, the department reports:

(i) Summary statistics and trends for demographic and related trauma care information for the state and for each emergency medical service/trauma care (EMS/TC) region;

(ii) Risk adjusted benchmarking and outcome measures, for system-wide evaluation and regional quality improvement programs;

(iii) Trends, patient care outcomes, and other data, for the state and each EMS/TC region, for the purpose of regional evaluation; and

(iv) Aggregate regional data upon request, excluding any confidential or identifying data.

(b) The department will provide reports to trauma services and qualified agencies upon request, according to the confidentiality provisions in subsection (2) of this section.

[Statutory Authority: RCW 70.168.060, 70.168.070, and 70.168.090. WSR 19-07-040, § 246-976-420, filed 3/14/19, effective 4/14/19. Statutory Authority: RCW 70.168.060 and 70.168.090. WSR 14-19-012, § 246-976-420, filed 9/4/14, effective 10/5/14; WSR 09-23-083, § 246-976-420, filed 11/16/09, effective 12/17/09; WSR 02-02-077, § 246-976-420, filed 12/31/01, effective 1/31/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-420, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-420, filed 12/23/92, effective 1/23/93.]

WAC 246-976-430 Trauma registry—Provider responsibilities. (1) A trauma care provider shall protect the confidentiality of data in their possession and as it is transferred to the department.

(2) A verified prehospital agency that transports trauma patients must:

(a) Provide an initial report of patient care to the receiving facility at the time the trauma patient is delivered as described in WAC 246-976-330.

(b) Within twenty-four hours after the trauma patient is delivered, send a complete patient care report to the receiving facility to include the data shown in Table A.

Table A:
Prehospital Patient Care Report Elements for the Washington Trauma Registry

Data Element	Prehospital-Transport:	Inter-Facility:
Incident Information		
Transporting emergency medical services (EMS) agency number	X	X
Unit en route date/time	X	
Patient care report number	X	X
First EMS agency on scene identification number	X	
Crew member level	X	X
Method of transport	X	X
Incident county	X	
Incident zip code	X	
Incident location type	X	
Patient Information		
Name	X	X
Date of birth, **or** age	X	X
Sex	X	X
Cause of injury	X	
Use of safety equipment	X	
Extrication required	X	
Transportation		
Facility transported from (code)		X
Times		
Unit notified by dispatch date/time	X	X
Unit arrived on scene date/time	X	X
Unit left scene date/time	X	X
Vital Signs		
Date/time of first vital signs taken	X	
First systolic blood pressure	X	
First respiratory rate	X	
First pulse	X	
First oxygen saturation	X	
First Glasgow coma score (GCS) with individual component values (eye, verbal, motor, total, and qualifier)	X	
Treatment		
Procedure performed	X	

(3) A designated trauma service must:

(a) Have a person identified as responsible for trauma registry activities, and who has completed the department trauma registry training course within eighteen months of hire. For level I-III trauma services the person identified must also complete the abbreviated injury scale (AIS) course within eighteen months of hire;

(b) Report data elements for all patients defined in WAC 246-976-420;

(c) Report patients with a discharge date for each calendar quarter in a department-approved format by the end of the following quarter;

(d) Have procedures in place for internal monitoring of data validity, which may include methods to reabstract data for accuracy; and

(e) Correct and resubmit records that fail the department's validity tests as described in WAC 246-976-420(7) within three months of notification of errors.

(4) A designated trauma rehabilitation service must provide data, as identified in subsection (7) of this section, to the trauma registry in a format determined by the department upon request.

(5) A designated trauma service must submit the following data elements for trauma patients:

(a) Record identification data elements must include:

(i) Identification (ID) of reporting facility;

(ii) Date and time of arrival at reporting facility;

(iii) Unique patient identification number assigned to the patient by the reporting facility.

(b) Patient identification data elements must include:

(i) Name;

(ii) Date of birth;

(iii) Sex;

(iv) Race;

(v) Ethnicity;

(vi) Last four digits of the patient's Social Security number;

(vii) Home zip code.

(c) Prehospital data elements must include:

(i) Date and time of incident;

(ii) Incident zip code;

(iii) Mechanism/type of injury;

(iv) External cause codes;

(v) Injury location codes;

(vi) First EMS agency on-scene identification (ID) number;

(vii) Transporting agency ID and unit number;

(viii) Transporting agency patient care report number;

(ix) Cause of injury;

(x) Incident county code;

(xi) Work related;

(xii) Use of safety equipment;

(xiii) Procedures performed.

(d) Prehospital vital signs data elements (from first EMS agency on scene) must include:

(i) Time;

(ii) First systolic blood pressure;

(iii) First respiratory rate;

(iv) First pulse rate;

(v) First oxygen saturation;

(vi) First GCS with individual component values (eye, verbal, motor, total, and qualifiers);

(vii) Intubated at time of first vital sign assessment;
(viii) Pharmacologically paralyzed at time of first vital sign assessment;
(ix) Extrication.
(e) Transportation data elements must include:
(i) Date and time unit dispatched;
(ii) Time unit arrived at scene;
(iii) Time unit left scene;
(iv) Transportation mode;
(v) Transferred in from another facility;
(vi) Transferring facility ID number.
(f) Emergency department (ED) data elements must include:
(i) Readmission;
(ii) Direct admit;
(iii) Time ED physician was called;
(iv) Time ED physician was available for patient care;
(v) Trauma team activated;
(vi) Level of trauma team activation;
(vii) Time of trauma team activation;
(viii) Time trauma surgeon was called;
(ix) Time trauma surgeon was available for patient care;
(x) Vital signs in ED, which must also include:
(A) First systolic blood pressure;
(B) First temperature;
(C) First pulse rate;
(D) First spontaneous respiration rate;
(E) Controlled rate of respiration;
(F) First oxygen saturation measurement;
(G) Lowest systolic blood pressure (SBP);
(H) GCS score with individual component values (eye, verbal, motor, total, and qualifiers);
(I) Whether intubated at time of ED GCS;
(J) Whether pharmacologically paralyzed at time of ED GCS;
(K) Height;
(L) Weight;
(M) Whether mass casualty incident disaster plan implemented.
(xi) Injury scores must include:
(A) Injury severity score;
(B) Revised trauma score on admission;
(C) Pediatric trauma score on admission;
(D) Trauma and injury severity score.
(xii) ED procedures performed;
(xiii) Blood and blood components administered;
(xiv) Date and time of ED discharge;
(xv) ED discharge disposition, including:
(A) If transferred, ID number of receiving hospital;
(B) Was patient admitted to hospital?
(C) If admitted, the admitting service;
(D) Reason for transfer (sending facility).
(g) Diagnostic and consultative data elements must include:
(i) Whether the patient received aspirin in the four days prior to the injury;
(ii) Whether the patient received any oral antiplatelet medication in the four days prior to the injury, such as clopidogrel (Plavix), or other antiplatelet medication, and, if so, include:
(A) Whether the patient received any oral anticoagulation medication in the four days prior to the injury, such as warfarin

(Coumadin), dabigatran (Pradaxa), rivaroxaban (Xarelto), or other anticoagulation medication, and, if so, include:

(B) The name of the anticoagulation medication.

(iii) Date and time of head computed tomography scan;

(iv) Date and time of first international normalized ratio (INR) performed at the reporting trauma service;

(v) Results of first INR preformed [performed] at the reporting trauma service;

(vi) Date and time of first partial thromboplastin time (PTT) performed at the reporting trauma service;

(vii) Results of first PTT performed at the reporting trauma service;

(viii) Whether any attempt was made to reverse anticoagulation at the reporting trauma service;

(ix) Whether any medication (other than Vitamin K) was first used to reverse anticoagulation at the reporting trauma service;

(x) Date and time of the first dose of anticoagulation reversal medication at the reporting trauma service;

(xi) Elapsed time from ED arrival;

(xii) Date of rehabilitation consult;

(xiii) Blood alcohol content;

(xiv) Toxicology results;

(xv) Whether a brief substance abuse assessment, intervention, and referral for treatment done at the reporting trauma service;

(xvi) Comorbid factors/preexisting conditions;

(xvii) Hospital events.

(h) Procedural data elements:

(i) First operation information must include:

(A) Date and time operation started;

(B) Operating room (OR) procedure codes;

(C) OR disposition.

(ii) For later operations information must include:

(A) Date and time of operation;

(B) OR procedure codes;

(C) OR disposition.

(i) Admission data elements must include:

(i) Date and time of admission order;

(ii) Date and time of admission or readmission;

(iii) Date and time of admission for primary stay in critical care unit;

(iv) Date and time of discharge from primary stay in critical care unit;

(v) Length of readmission stay(s) in critical care unit;

(vi) Other in-house procedures performed (not in OR).

(j) Disposition data elements must include:

(i) Date and time of facility discharge;

(ii) Most recent ICD diagnosis codes/discharge codes, including nontrauma diagnosis codes;

(iii) Disability at discharge (feeding/locomotion/expression);

(iv) Total ventilator days;

(v) Discharge disposition location;

(vi) If transferred out, ID of facility the patient was transferred to;

(vii) If transferred to rehabilitation, facility ID;

(viii) Death in facility.

(A) Date and time of death;

(B) Location of death;

(C) Autopsy performed;
(D) Organ donation requested;
(E) Organs donated.
(ix) End-of-life care and documentation;
(A) Whether the patient had an end-of-life care document before injury;
(B) Whether there was any new end-of-life care decision documented during the inpatient stay at the reporting trauma service;
(C) Whether the patient receive a consult for comfort care, hospice care, or palliative care during the inpatient stay at the reporting trauma service;
(D) Whether the patient received any comfort care, in-house hospice care, or palliative care during the inpatient stay (i.e., was acute care withdrawn) at the reporting trauma service;
(k) Financial information must include:
(i) Total billed charges;
(ii) Payer sources (by category);
(iii) Reimbursement received (by payer category).
(6) Designated trauma rehabilitation services must provide the following data upon request by the department for patients identified in WAC 246-976-420(3).
(a) Data submission elements will be based on the current inpatient rehabilitation facility patient assessment instrument (IRF-PAI). All individual data elements included in the IRF-PAI categories below and defined in the data dictionary must be submitted upon request:
(i) Identification information;
(ii) Payer information;
(iii) Medical information;
(iv) Function modifiers (admission and discharge);
(v) Functional measures (admission and discharge);
(vi) Discharge information;
(vii) Therapy information.
(b) In addition to IRF-PAI data elements each rehabilitation service must submit the following information to the department:
(i) Admit from (facility ID);
(ii) Payer source (primary and secondary);
(iii) Total charges;
(iv) Total remitted reimbursement.

[Statutory Authority: RCW 70.168.060, 70.168.070, and 70.168.090. WSR 19-07-040, § 246-976-430, filed 3/14/19, effective 4/14/19. Statutory Authority: RCW 70.168.060 and 70.168.090. WSR 14-19-012, § 246-976-430, filed 9/4/14, effective 10/5/14; WSR 09-23-083, § 246-976-430, filed 11/16/09, effective 12/17/09; WSR 02-02-077, § 246-976-430, filed 12/31/01, effective 1/31/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-430, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-430, filed 12/23/92, effective 1/23/93.]

DESIGNATION OF TRAUMA CARE FACILITIES

WAC 246-976-580 Trauma designation process. The department designates health care facilities to provide adult and pediatric acute care trauma services ("trauma services") and adult and pediatric trau-

ma rehabilitation services ("trauma rehabilitation services") as part of the statewide emergency medical services and trauma care (EMS&TC) system. This section describes the designation process.

(1) The department must:

(a) Provide written notification to all licensed hospitals and to other health care facilities that a new designation period is beginning. The written notification and the EMS&TC regional plans are posted on the department's website;

(b) Provide a trauma designation application schedule outlining the steps and timeline requirements for a facility to apply for trauma service designation. The schedule must provide each facility at least ninety days to complete an application for trauma designation. The application schedule is posted on the department's website;

(c) Provide an application for each level, type and combination of designation. Designation applications are released region by region, according to the established schedule;

(d) Conduct a site review for any hospital applying for level I, II, or III adult and pediatric trauma service designation to determine compliance with required standards;

(e) Initiate a three-year contract with successful applicants to authorize participation in the trauma system.

(2) To apply for trauma service designation the health care facility must do the following according to the application schedule:

(a) Request an application;

(b) Submit a letter of intent to apply for trauma service designation indicating what level they are applying for;

(c) Submit a completed application(s);

(d) For health care facilities applying for level I, II, III adult and pediatric trauma service designation, the facility must complete a site review arranged and conducted by the department according to the following process:

(i) The department will contract with trauma surgeons and trauma nurses to conduct the site review. The review team members must:

(A) Work outside the state of Washington, for level I and II site reviews;

(B) Work outside the applicant's EMS&TC region, for level III site reviews;

(C) Maintain the confidentiality of all documents examined, in accordance with RCW 70.41.200 and 70.168.070. This includes, but is not limited to, all trauma patient data, staff discussions, patient, provider, and facility care outcomes, and any reports resulting from the site review;

(D) Present their preliminary findings to the health care facility at the end of the site review visit;

(ii) The department will provide the applicant the names of review team members prior to the site review. Any objections must be sent to the department within ten days of receiving the department's notification of review team members;

(iii) A site review fee, as established in WAC 246-976-990, is charged and must be paid by the health care facility to the department prior to the site review. A standard fee schedule is posted on the department's website. For facilities applying for more than one type of designation or for joint designation, fee rates can be obtained by contacting the department;

(iv) The applicant must provide the department and the site review team full access to the facility, facility staff, and all records and documents concerning trauma care including trauma patient data,

education, training and credentialing documentation, standards of care, policies, procedures, protocols, call schedules, medical records, quality improvement materials, receiving facility patient feedback, and other relevant documents;

(e) For health care facilities applying for level IV or V trauma service designation, level I or II trauma rehabilitation service designation or level I pediatric trauma rehabilitation service designation, the department may, at its discretion, conduct a site review as part of the application process to determine compliance with required standards. If a site review is conducted, the process will be the same as identified in (d) of this subsection, except a site review fee will not be charged.

(3) The department will designate the health care facilities it considers most qualified to provide trauma care services including when there is competition for trauma service designation within a region. There is competition for designation within a region when the number of applications for a level and type of designation is more than the maximum number of trauma services identified in the approved EMS&TC regional plan. The department will evaluate, at a minimum, the following in making its decisions:

(a) The quality of the health care facility's performance based on:

(i) The submitted application, attachments, and any other information the department requests from the facility to verify compliance, or the ability to comply with trauma standards;

(ii) Recommendations from the site review team;

(iii) Trauma patient outcomes during the previous designation period, if applicable;

(iv) Compliance with the contract during the previous designation period, if applicable;

(b) The health care facility's conformity with the EMS&TC regional and state plans, based on:

(i) The impact of the facility's designation on the effectiveness of the trauma system;

(ii) Patient volumes for the area;

(iii) The number, level, and distribution of trauma services identified in the state and approved regional plans;

(iv) The facility's ability to comply with state and regional EMS&TC plan goals.

(4) After trauma service designation decisions are made in a region, the department will:

(a) Notify each applicant in writing of the department's designation decision;

(b) Send each applicant a written report summarizing the department's findings, recommendations and additional requirements to maintain designation. If a site review was conducted as part of the application process, the review team findings and recommendations are also included in the written report. Reports are sent:

(i) Within sixty days of announcing designation decisions for level IV and V trauma services and trauma rehabilitation services;

(ii) Within one hundred twenty days of the site review for level I, II and III adult and pediatric trauma services and any other facility that received a site review as part of the application process;

(c) Notify the EMS&TC regional council of designation decisions within the region and all subsequent changes in designation status;

(d) Initiate a trauma designation contract with successful applicants. The contract will include:

(i) Authority from the department to participate in the state trauma system, receive trauma patients from EMS agencies, and provide trauma care services for a three-year period;

(ii) The contractual and financial requirements and responsibilities of the department and the trauma service;

(iii) A provision to allow the department to monitor compliance with trauma service standards;

(iv) A provision to allow the department to have full access to trauma patient data, the facility, equipment, staff and their credentials, education, training documentation, and all trauma care documents such as: Standards of care, policies, procedures, protocols, call schedules, medical records, quality improvement documents, receiving facility patient feedback, and other relevant documents;

(v) The requirement to maintain confidentiality of information relating to individual patient's, provider's and facility's care outcomes under RCW 70.41.200 and 70.168.070;

(e) Notify the designated trauma service and other interested parties in the region of the next trauma designation application process at least one hundred fifty days before the contract expires.

(5) Designated trauma services may ask the department to conduct a site review for technical assistance at any time during the designation period. The department has the right to require reimbursement for the costs of conducting the site review.

(6) The department will not approve an application for trauma service designation if the applicant:

(a) Is not the most qualified, when there is competition for designation; or

(b) Does not meet the trauma care standards for the level applied for; or

(c) Does not meet the requirements of the approved EMS&TC regional plan; or

(d) Has made a false statement about a material fact in its designation application; or

(e) Refuses to permit the department to examine any part of the facility that relates to the delivery of trauma care services, including, but not limited to, records, documentation, or files.

(7) If the department denies an application, the department will send the facility a written notice to explain the reasons for denial and to explain the facility's right to appeal the department's decision in accordance with chapters 34.05 RCW and 246-10 WAC.

(8) To ensure adequate trauma care in the state, the department may:

(a) Provisionally designate health care facilities that are not able to meet all the requirements of this chapter. The provisional designation will not be for more than two years. A department-approved plan of correction must be prepared by the health care facility specifying steps necessary to bring the facility into compliance and an expected date of compliance. The department may conduct a site review to verify compliance with required standards. If a site review is conducted, the department has the right to require reimbursement for the cost of conducting the site review;

(b) Consider additional applications at any time, regardless of the established schedule, if necessary to attain the numbers and levels of trauma services identified in the approved EMS&TC regional and state plan;

(c) Consider applications from hospitals located and licensed in adjacent states. The department will evaluate an out-of-state applica-

tion in the same manner as all other applications. However, if the out-of-state applicant is designated as a trauma service in an adjacent state with an established trauma system whose standards meet or exceed Washington's standards and there is no competition for designation at that level, then the department may use the administrative findings, conclusions, and decisions of the adjacent state's designation evaluation to make the decision to designate. Additional information may be requested by the department to make a final decision.

(9) The department may suspend or revoke a trauma designation if the facility or any owner, officer, director, or managing employee:

(a) Is substantially out of compliance with trauma care standards WAC 246-976-700 through 246-976-800 or chapter 70.168 RCW and has refused or is unwilling to comply after a reasonable period of time;

(b) Makes a false statement of a material fact in the designation application, or in any document required or requested by the department, or in a matter under investigation;

(c) Prevents, interferes with, or attempts to impede in any way, the work of a department representative in the lawful enforcement of chapter 246-976 WAC, 34.05 RCW, 246-10 WAC, or 70.168 RCW;

(d) Uses false, fraudulent, or misleading advertising, or makes any public claims regarding the facility's ability to care for non-trauma patients based on its trauma designation status;

(e) Misrepresents or is fraudulent in any aspect of conducting business.

(10) The Administrative Procedure Act, chapter 34.05 RCW, and chapter 246-10 WAC govern the suspension and revocation process. The department will use the following process to suspend or revoke a facility's trauma designation:

(a) The department will send the facility a written notice to explain the reasons it intends to suspend or revoke the designation and to explain the facility's right to a hearing to contest the department's intended action under WAC 246-10-201 through 246-10-205;

(b) The notice will be sent at least twenty-eight days before the department takes action, unless it is a summary suspension, as provided for in the Administrative Procedure Act, chapter 34.05 RCW and WAC 246-10-301 through 246-10-306;

(c) If a facility requests a hearing within twenty-eight days of the date the notice was mailed, a hearing before a health law judge will be scheduled. If the department does not receive the facility's request for a hearing within twenty-eight days of the date the notice was mailed, the facility will be considered in default under WAC 246-10-204;

(d) For nonsummary suspensions, in addition to its request for a hearing, the facility may submit a plan within twenty-eight days of receiving the notice of the department's intent to suspend, describing how it will correct deficiencies:

(i) The department will approve or disapprove the plan within thirty days of receipt;

(ii) If the department approves the plan, the facility must begin to implement it within thirty days;

(iii) The facility must notify the department when the problems are corrected;

(iv) If, prior to sixty days before the scheduled hearing, the facility is able to successfully demonstrate to the department that it is meeting the requirements of chapters 246-976 WAC and 70.168 RCW, which may require a site review at the facility's expense, the department will withdraw its notice of intent to suspend designation;

(e) The department will notify the regional EMS&TC council of the actions it has taken.

(11) A facility may seek judicial review of the department's final decision under the Administrative Procedure Act, RCW 34.05.510 through 34.05.598.

(12) A newly designated or upgraded trauma service must meet education requirements for all applicable personnel according to the following schedule:

(a) At the time of the new designation, twenty-five percent of all personnel must meet the education and training requirements in WAC 246-976-700 through 246-976-800;

(b) At the end of the first year of designation, fifty percent of all personnel must meet the education and training requirements in WAC 246-976-700 through 246-976-800;

(c) At the end of the second year of designation, seventy-five percent of all personnel must meet the education and training requirements defined in WAC 246-976-700 through 246-976-800;

(d) At the end of the third year of designation, and all subsequent designation periods, ninety percent of all personnel must meet the education and training requirements defined in WAC 246-976-700 through 246-976-800.

(13) All currently designated trauma services must have a written education plan with a process for tracking and assuring that new physicians and staff meet all trauma education requirements within the first eighteen months of employment.

[Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 18-24-082, § 246-976-580, filed 12/3/18, effective 1/3/19. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070. WSR 09-23-085, § 246-976-580, filed 11/16/09, effective 12/17/09.]

WAC 246-976-700 Trauma service standards.

WAC 246-976-700 Trauma Service Standards	**Adult Levels**					**Pediatric Levels**		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(1) A written trauma scope of service outlining the trauma care resources and capabilities available twenty-four hours every day for:	X	X	X	X	X	X	X	X
(a) Adult and pediatric trauma patient care;	X	X	X	X	X			
(b) Pediatric trauma patient care.						X	X	X
(2) A trauma medical director responsible for the organization and direction of the trauma service who:	X	X	X	X	X	X	X	X
(a) Is currently certified in advanced trauma life support (ATLS);	X	X	X			X	X	X
(b) Is a board-certified general surgeon;	X	X						
(c) Is a board-certified general surgeon **or** general surgeon trained in advanced cardiac life support (ACLS);			X					
(d) Is a board-certified general surgeon, emergency physician, a general surgeon ACLS trained with current certification in advanced trauma life support (ATLS) or a physician ACLS trained and current certification in ATLS;				X				
(e) Is a board-certified general surgeon, emergency physician, a physician ACLS trained with current certification in ATLS, or a physician assistant or advanced registered nurse practitioner ACLS trained who is currently certified in ATLS;					X			

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(f) Is a board-certified pediatric surgeon or a board-certified general surgeon with special competence in the care of pediatric patients;						X	X	
(g) Is a board-certified general surgeon with special competence in the care of pediatric patients or a general surgeon ACLS trained and with special competence in the care of pediatric patients;								X
(h) Must complete thirty-six hours in three years of verifiable, external, trauma-related continuing medical education (CME);	X	X				X	X	
(i) Meets the pediatric education requirement (PER) as defined in subsection (27) of this section;	X	X	X	X	X	X	X	X
(j) Must have responsibility and authority for determining each general surgeon's ability to participate on the trauma call panel based on an annual review, conducted in conjunction with medical staffing and with authority through the trauma quality improvement program and hospital policy;	X	X	X			X	X	X
(k) Is a member of and actively participates in a regional or national trauma organizations.	X	X				X	X	
(3) A trauma program manager or trauma service coordinator responsible for the overall operation of trauma service who:	X	X	X	X	X	X	X	X
(a) Is a registered nurse;	X	X	X	X	X	X	X	X
(b) Has taken ACLS;	X	X	X	X	X	X	X	X
(c) Has successfully completed a trauma nursing core course (TNCC) or a department approved equivalent course, and successfully completes thirty-six hours of trauma-related education every three years in either external continuing education or in an internal education process conducted by the trauma program. The trauma education must include, but is not limited to, the following topics:	X	X	X	X	X	X	X	X
(i) Mechanism of injury;	X	X	X	X	X	X	X	X
(ii) Shock and fluid resuscitation;	X	X	X	X	X	X	X	X
(iii) Initial assessment;	X	X	X	X	X	X	X	X
(iv) Stabilization and transport.	X	X	X	X	X	X	X	X
(d) Has taken pediatric advanced life support (PALS) or emergency nursing pediatric course (ENPC), and thereafter meets the PER contact hours as defined in subsection (27) of this section;	X	X	X	X	X			
(e) Has current PALS or ENPC certification;						X	X	X
(f) Has attended a trauma program manager orientation course provided by the department or a department approved equivalent, within the first eighteen months in the role;	X	X	X	X	X	X	X	X
(g) Is responsible for the overall supervision of the trauma registry and the quality of data submitted to the registry.	X	X	X	X	X	X	X	X
(4) A multidisciplinary trauma quality improvement program that must:	X	X	X	X	X	X	X	X
(a) Be led by the multidisciplinary trauma service committee:	X	X	X	X	X	X	X	X
(i) The trauma medical director serves as chair of the multidisciplinary trauma service committee;	X	X	X	X	X	X	X	X
(ii) The trauma medical director must attend a minimum of fifty percent of the peer review committee meetings;	X	X	X	X	X	X	X	X
(iii) The trauma medical director and trauma program manager must have the authority and be empowered by the hospital governing body to lead the program to ensure compliance with trauma service standards.	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(b) Demonstrate a continuous quality improvement process supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement;	X	X	X	X	X	X	X	X
(c) Have membership representation and participation that reflects the facility's trauma scope of service;	X	X	X	X	X	X	X	X
(d) Have an organizational structure that facilitates the process of quality improvement with a reporting relationship to the hospital's administrative team and medical executive committee that ensures adequate evaluation of all aspects of trauma care;	X	X	X	X	X	X	X	X
(e) Have authority to establish trauma care standards and implement patient care policies, procedures, guidelines, and protocols throughout the hospital and the trauma service must use clinical practice guidelines, protocols, and algorithms derived from evidence-based validated resources;	X	X	X	X	X	X	X	X
(f) Have a current trauma quality improvement plan that outlines the trauma service's quality improvement process;	X	X	X	X	X	X	X	X
(g) Have a process to monitor and track compliance with the trauma care standards using audit filters and benchmarks;	X	X	X	X	X	X	X	X
(h) Have a process to evaluate the care provided to trauma patients and to resolve identified prehospital, physician, nursing, or system issues;	X	X	X	X	X	X	X	X
(i) Have a process in which outcome measures are documented within the trauma quality improvement program's written plan which must be reviewed and updated at least annually. Outcome measures will include, at a minimum:	X	X	X	X	X	X	X	X
(i) Mortality (with and without opportunities for improvement);								
(ii) Trauma surgeon response time (level I-III);								
(iii) Undertriage rate;								
(iv) Emergency department length of stay greater than three hours for patients transferred out;								
(v) Missed injuries;								
(vi) Complications.								
(j) Have a process for correcting problems or deficiencies;	X	X	X	X	X	X	X	X
(k) Have a process for problem resolution, outcome improvements, and assurance of safety. This process must be readily identifiable through methods of monitoring, reevaluation, benchmarking, and documentation;	X	X	X	X	X	X	X	X
(l) Have a process to continuously evaluate compliance with full and modified (if used) trauma team activation criteria as follows:	X	X	X	X	X	X	X	X
(i) The attending surgeon's arrival within fifteen minutes for level II and thirty minutes for level III services for patients with appropriate activation criteria must be monitored by the hospital's trauma quality improvement program;	X	X	X			X	X	X
(ii) All trauma team activations must be categorized by the level of response activation and quantified by number and percentage;	X	X	X	X	X	X	X	X
(iii) Trauma surgeon response time to full activations and for back-up call response must be determined and monitored. Variances should be documented and reviewed for reason for delay, opportunities for improvement, and corrective actions; and	X	X	X			X	X	X
(iv) Rates of undertriage must be monitored and reviewed quarterly.	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(m) Have assurance from other hospital quality improvement committees, including peer review if conducted separately from the multidisciplinary trauma service committee, that resolution was achieved on trauma-related issues. The following requirements must also be satisfied:	X	X	X	X	X	X	X	X
(i) Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion;	X	X	X	X	X	X	X	X
(ii) A process must be in place to ensure that the trauma program manager receives feedback from peer review for trauma-related issues;	X	X	X	X	X	X	X	X
(iii) All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review;	X	X	X	X	X	X	X	X
(iv) This effort must involve the participation and leadership of the trauma medical director and any departments, such as: General surgery, emergency medicine, orthopedics, neurosurgery, anesthesia, critical care, lab and radiology; and	X	X	X	X	X	X	X	X
(v) The multidisciplinary trauma peer review committee must systematically review significant complications and process variances associated with unanticipated outcomes and determine opportunities for improvement.	X	X	X	X	X	X	X	X
(n) Have a process to ensure the confidentiality of patient and provider information, in accordance with RCW 70.41.200 and 70.168.090;	X	X	X	X	X	X	X	X
(o) Have a process to communicate with and provide feedback to referring trauma services and trauma care providers;	X	X	X	X	X	X	X	X
(p) Be able to integrate trauma quality improvement into the hospital's quality improvement program for level III, IV, V trauma services or level III pediatric trauma services with a total annual trauma volume of less than one hundred patients; however, trauma care must be formally addressed in accordance with the quality improvement requirements in this subsection. In that case, the trauma medical director is not required to serve as chair;			X	X	X			X
(q) Have a pediatric-specific trauma quality improvement program for a trauma service admitting at least one hundred pediatric trauma patients annually. For a trauma service admitting less than one hundred pediatric trauma patients annually, or that is transferring trauma patients, the trauma service must review each case for timeliness and appropriateness of care;	X	X	X	X	X	X	X	X
(r) Be a multidisciplinary trauma quality improvement program that transcends normal department hierarchies and includes:	X	X	X	X	X	X	X	X
Identified medical staff representatives or their designees from departments of general surgery, emergency medicine, orthopedics, neurosurgery, anesthesiology, critical care, and radiology who must participate actively in the multidisciplinary trauma quality improvement program with at least fifty percent attendance at peer review committee meetings.	X	X	X			X	X	X
(s) Use risk-adjusted data for benchmarking and performance improvement:	X	X	X	X	X	X	X	X
(i) The risk-adjusted benchmarking system to measure performance must be the American College of Surgeons Trauma Quality Improvement Program (TQIP);	X	X				X	X	
(ii) Data must be collected in compliance with the National Trauma Data Standard (NTDS) and submitted to the National Trauma Data Bank® (NTDB®) every year in a timely fashion so that data can be aggregated and analyzed at the national level;	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(iii) Use risk-adjusted data provided by the state for the purposes of benchmarking and performance improvement.			X	X	X			X
(5) Written trauma service standards of care to ensure appropriate care throughout the facility for:	X	X	X	X	X	X	X	X
(a) Adult and pediatric trauma patients;	X	X	X	X	X			
(b) Pediatric trauma patients.						X	X	X
(6) Participation in the regional quality improvement program as defined in WAC 246-976-910.	X	X	X	X	X	X	X	X
(7) Participation in the Washington state trauma registry as defined in WAC 246-976-430.	X	X	X	X	X	X	X	X
(8) Written transfer-in guidelines consistent with the facility's designation level and trauma scope of service. The guidelines must identify the type, severity and complexity of injuries the facility can safely accept, admit, and provide with definitive care.	X	X	X	X	X	X	X	X
(9) Written transfer-out guidelines consistent with the facility's designation level and trauma scope of service. The guidelines must identify the type, severity and complexity of injuries that exceed the resources and capabilities of the trauma service.	X	X	X	X	X	X	X	X
(a) Collaborative treatment and transfer guidelines reflecting facilities' capabilities must be developed and regularly reviewed, with input from higher-level trauma services that receive these patients;			X	X	X			
(b) The decision to transfer an injured patient to a specialty care facility in an acute situation must be based solely on the needs of the patient and not on the requirements of the patient's specific provider network, health maintenance organization, a preferred provider organization, or the patient's ability to pay;	X	X	X	X	X	X	X	X
(c) Acute transfers out must be subjected to individual case review to determine the rationale for transfer, appropriateness of care, and opportunities for improvement. Follow-up from the center to which the patient was transferred should be obtained as part of the case review; and	X	X	X	X	X	X	X	X
(d) Trauma patients must not be admitted or transferred by a primary care physician without the knowledge and consent of the trauma service. The quality improvement program should monitor adherence to this guideline.	X	X	X			X	X	X
(10) Written interfacility transfer agreements with all trauma services that receive the facility's trauma patients. Agreements must include a process to identify medical control during the interfacility transfer, and address the responsibilities of the trauma service, the receiving hospital, and the verified prehospital transport agency. All trauma patients must be transported by a trauma verified prehospital transport agency.	X	X	X	X	X	X	X	X
(11) An air medical transport plan addressing the receipt or transfer of trauma patients with a heli-stop, landing zone, or airport located close enough to permit the facility to receive or transfer trauma patients by fixed-wing or rotary-wing aircraft.	X	X	X	X	X	X	X	X
(12) A written diversion protocol for the emergency department to divert trauma patients from the field to another trauma service when resources are temporarily unavailable. The process must include:	X	X	X	X	X	X	X	X
(a) Trauma service and patient criteria used to decide when diversion is necessary;	X	X	X	X	X	X	X	X
(b) How the divert status will be communicated to the nearby trauma services and prehospital agencies;	X	X	X	X	X	X	X	X
(c) How the diversion will be coordinated with the appropriate prehospital agency;	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(d) A method of documenting/tracking when the trauma service is on trauma divert, including the date, time, duration, reason, and decision maker;	X	X	X	X	X	X	X	X
(e) Assurance that the decision to divert patients from the emergency department is communicated to the trauma surgeon on-call;	X	X	X			X	X	X
(f) Involvement of the trauma surgeon in the decision regarding diversion each time the center goes on bypass;	X	X				X	X	
(g) Routine monitoring, documenting and reporting of trauma center diversion hours, including the reason for initiating the diversion policy. Trauma center diversion must not exceed five percent of the time.	X	X	X			X	X	X
(13) A trauma team activation protocol consistent with the facility's trauma scope of service. The protocol must:	X	X	X	X	X	X	X	X
(a) Define the physiologic, anatomic, and mechanism of injury criteria used to activate the full and modified (if used) trauma teams;	X	X	X	X	X	X	X	X
(b) Identify members of the full and modified (if used) trauma teams consistent with the provider requirements of this chapter;	X	X	X	X	X	X	X	X
(c) Define the process to activate the trauma team. The process must:	X	X	X	X	X	X	X	X
(i) Consistently apply the trauma service's established criteria;	X	X	X	X	X	X	X	X
(ii) Use information obtained from prehospital providers or an emergency department assessment for patients not delivered by a prehospital agency;	X	X	X	X	X	X	X	X
(iii) Be applied regardless of time post injury or previous care, whether delivered by prehospital or other means and whether transported from the scene or transferred from another facility;	X	X	X	X	X	X	X	X
(iv) Include a method to upgrade a modified activation to a full activation when newly acquired information warrants additional capabilities and resources;	X	X	X	X	X	X	X	X
(v) Include the mandatory presence of a general surgeon for full trauma team activations. The general surgeon assumes leadership and overall care using professional judgment regarding the need for surgery or transfer;	X	X	X			X	X	X
(vi) Include the mandatory presence of a general surgeon if general surgery services are included in the facility's trauma scope of service. The general surgeon assumes leadership and overall care using professional judgment regarding the need for surgery or transfer;				X				
(vii) For trauma team activations in pediatric designated trauma services (within five minutes for level I, twenty minutes for level II or thirty minutes for level III), one of the following pediatric physician specialists must respond:						X	X	X
(A) A pediatric surgeon;								
(B) A pediatric emergency medicine physician;								
(C) A pediatric intensivist;								
(D) A pediatrician;								
(E) A postgraduate year two or higher pediatric resident.								
(viii) Require multisystem injured patients to be admitted to or evaluated by an identifiable surgical service staffed by credentialed trauma providers.	X	X	X					
(14) Emergency care services available twenty-four hours every day with:	X	X	X	X	X	X	X	X
(a) An emergency department (except for level V clinics);	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(b) The ability to resuscitate and stabilize adult and pediatric trauma patients in a designated resuscitation area;	X	X	X	X	X			
(c) The ability to resuscitate and stabilize pediatric trauma patients in a designated resuscitation area;						X	X	X
(d) A medical director, who:	X	X	X			X	X	X
(i) Is board-certified in emergency medicine, board-certified in general surgery, or is board-certified in another relevant specialty practicing emergency medicine as their primary practice;	X	X	X					
(ii) Is board-certified in pediatric emergency medicine, board-certified in emergency medicine with special competence in the care of pediatric patients, board-certified in general surgery with special competence in the care of pediatric patients, or board-certified in a relevant specialty practicing emergency medicine as their primary practice with special competence in the care of pediatric patients.						X	X	X
(e) Emergency physicians who:	X	X	X	X	X	X	X	X
(i) Are board-certified in emergency medicine or board-certified in a relevant specialty practicing emergency medicine as their primary practice. This requirement can be met by a postgraduate year two or higher emergency medicine or general surgery resident working under the direct supervision of the attending emergency physician. The resident must be available within five minutes of notification of the patient's arrival to provide leadership and care until arrival of the general surgeon;	X	X						
(ii) Are board-certified in pediatric emergency medicine, are board-certified in emergency medicine with special competence in the care of pediatric patients, **or** are board-certified in a relevant specialty practicing emergency medicine as their primary practice with special competence in the care of pediatric patients. This requirement can be met by a postgraduate year two or higher emergency medicine or general surgery resident with special competence in the care of pediatric trauma patients and working under the direct supervision of the attending emergency physician. The resident must be available within five minutes of notification of the patient's arrival to provide leadership and care until arrival of the general surgeon;						X	X	
(iii) Are board-certified in emergency medicine or another relevant specialty practicing emergency medicine as their primary practice **or** physicians practicing emergency medicine as their primary practice with current certification in ACLS and ATLS;			X					
(iv) Are board-certified in pediatric emergency medicine, are board-certified in emergency medicine or surgery, with special competence in the care of pediatric patients, are board-certified in a relevant specialty practicing emergency medicine as their primary practice, with special competence in the care of pediatric patients, **or** are physicians with current certification in ATLS who are practicing emergency medicine as their primary practice with special competence in the care of pediatric patients;								X
(v) Are board-certified in emergency medicine or another relevant specialty and practicing emergency medicine as their primary practice **or** physicians with current certification in ACLS and ATLS. A physician assistant (PA) or advanced registered nurse practitioner (ARNP) current in ACLS and ATLS may initiate evaluation and treatment upon the patient's arrival in the emergency department until the arrival of the physician;				X				

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(vi) Are board-certified or qualified in emergency medicine, surgery, or other relevant specialty and practicing emergency medicine as their primary practice **or** are physicians with current certification in ACLS and ATLS, **or** are PAs or ARNPs with current certification in ACLS and ATLS;					X			
(vii) Are available within five minutes of notification of the patient's arrival in the emergency department;	X	X	X			X	X	X
(viii) Are on-call and available within twenty minutes of notification of the patient's arrival in the emergency department;				X	X			
(ix) Are currently certified in ACLS and ATLS. This requirement applies to all emergency physicians and residents who care for trauma patients in the emergency department except this requirement does not apply to physicians who are board-certified in emergency medicine **or** board-certified in another relevant specialty and practicing emergency medicine as their primary practice;	X	X	X	X	X			
(x) Are currently certified in ATLS. This requirement applies to all emergency physicians and residents who care for pediatric patients in the emergency department except this requirement does not apply to physicians who are board-certified in pediatric emergency medicine, board-certified in emergency medicine, **or** board-certified in another relevant specialty and practicing emergency medicine as their primary practice;						X	X	X
(xi) Meet the PER as defined in subsection (27) of this section;	X	X	X	X	X	X	X	X
(xii) If the liaison or designee from emergency medicine, must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(xiii) If they are emergency physicians who participate on the trauma team, they must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(xiv) Nonboard-certified emergency physicians and advanced practitioners who participate in the initial care or evaluation of trauma activated patients in the emergency department must have current ATLS certification;	X	X	X	X	X	X	X	X
(xv) Must be able to provide initial resuscitative care to known trauma activated patients;	X	X	X			X	X	X
(xvi) Have completed appropriate orientation, credentialing, initial ED management/evaluation processes, and skill maintenance for advanced practitioners who participate in the initial assessment of trauma patients.	X	X	X	X	X	X	X	X
(f) Emergency care registered nurses (RNs) who:	X	X	X	X	X	X	X	X
(i) Are in the emergency department and available within five minutes of notification of patient's arrival;	X	X	X			X	X	X
(ii) Are in-house and available within five minutes of notification of the patient's arrival;				X	X			
(iii) Have current certification in ACLS;	X	X	X	X	X			
(iv) Have successfully completed TNCC or a department approved equivalent course;	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(v) Have completed twelve hours of trauma related education every designation period. The trauma education must include, but is not limited to, the following topics:								
(A) Mechanism of injury;	X	X	X	X		X	X	X
(B) Shock and fluid resuscitation;								
(C) Initial assessment;								
(D) Stabilization and transport.								
(vi) Meet the PER as defined in subsection (27) of this section.	X	X	X	X	X	X	X	X
(g) Standard emergency equipment for the resuscitation and life support of adult and pediatric trauma patients, including:	X	X	X	X	X	X	X	X
(i) Immobilization devices:	X	X	X	X	X	X	X	X
(A) Back board;	X	X	X	X	X	X	X	X
(B) Cervical injury;	X	X	X	X	X	X	X	X
(C) Long-bone.	X	X	X	X	X	X	X	X
(ii)(A) Infusion control device:	X	X	X	X	X	X	X	X
(B) Rapid infusion capability.	X	X	X			X	X	X
(iii) Intraosseous devices;	X	X	X	X	X	X	X	X
(iv) Sterile surgical sets:	X	X	X	X	X	X	X	X
(A) Thoracostomy with closed drainage devices;	X	X	X	X	X	X	X	X
(B) Emergency transcutaneous airway;	X	X	X	X	X	X	X	X
(C) Bedside ultrasound;	X	X	X	X		X	X	X
(D) Thoracotomy;	X	X	X			X	X	X
(v) Thermal control equipment:	X	X	X	X	X	X	X	X
(A) Blood and fluid warming;	X	X	X	X	X	X	X	X
(B) Thermometer capable of detecting hypothermia;	X	X	X	X	X	X	X	X
(C) Patient warming and cooling.	X	X	X	X	X	X	X	X
(vi) Other equipment:	X	X	X	X	X	X	X	X
(A) Medication chart, tape, or other system to assure ready access to information on proper doses-per-kilogram for resuscitation drugs and equipment sizes for pediatric patients;	X	X	X	X	X	X	X	X
(B) Pediatric emergency airway equipment readily available or transported in-house with the pediatric patient for evaluation, treatment or diagnostics, including bag-valve masks, face masks, and oral/nasal airways.	X	X	X	X	X	X	X	X
(15) Respiratory therapy services, with a respiratory care practitioner available within five minutes of notification of patient's arrival.	X	X	X			X	X	X
(16) Diagnostic imaging services (except for level V clinics) with:	X	X	X	X	X	X	X	X
(a) A radiologist in person or by teleradiology, who is:	X	X	X			X	X	X
(i) On-call and available within twenty minutes of the trauma team leader's request;	X	X				X	X	
(ii) On-call and available within thirty minutes of the trauma team leader's request;			X					X
(iii) Board certified or eligible for certification by an appropriate radiology board according to current requirements for licensed radiologists who take trauma call.	X	X				X	X	
(b) Personnel able to perform routine radiological capabilities who are:	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(i) Available within five minutes of notification of the patient's arrival;	X	X				X	X	
(ii) On-call and available within twenty minutes of notification of the patient's arrival.			X	X	X			X
(c) A technologist able to perform computerized tomography who is:	X	X	X			X	X	X
(i) Available within five minutes of the trauma team leader's request;	X					X		
(ii) On-call and available within twenty minutes of the trauma team leader's request.		X	X				X	X
(d) A radiologic peer review process that reviews routine interpretations of images for accuracy. Determinations related to trauma patients must be communicated to the trauma program quality committee;	X	X	X			X	X	X
(e) Angiography with a technologist on-call and available within thirty minutes of the trauma team leader's request;	X	X				X	X	
(f) Magnetic resonance imaging with a technologist on-call and available within sixty minutes of the trauma team leader's request;	X	X				X	X	
(g) Sonography with a technologist on-call and available within thirty minutes of the trauma team leader's request;	X	X				X	X	
(h) Interventional radiology services on-call and available within thirty minutes of the trauma team leader's request;	X	X				X	X	
(i) Radiologists who are involved, at a minimum, in protocol development and trend analysis that relate to diagnostic imaging;	X	X	X			X	X	X
(j) Facilities that have a mechanism in place to view radiographic imaging from referring hospitals that are within their catchment area.	X	X				X	X	
(17) Clinical laboratory services (except for level V clinics), with:	X	X	X	X	X	X	X	X
(a) Lab services available within five minutes of notification of the patient's arrival;	X	X	X			X	X	X
(b) Lab services on-call and available within twenty minutes of notification of the patient's arrival;				X	X			
(c) Blood gases and pH determination;	X	X	X	X		X	X	X
(d) Coagulation studies;	X	X	X	X	X	X	X	X
(e) Drug or toxicology measurements;	X	X	X	X	X	X	X	X
(f) Microbiology;	X	X	X	X	X	X	X	X
(g) Serum alcohol determination;	X	X	X	X	X	X	X	X
(h) Serum and urine osmolality;	X	X				X	X	
(i) Standard analysis of blood, urine, and other body fluids.	X	X	X	X	X	X	X	X
(18) Blood and blood-component services (except for level V clinics) with:	X	X	X	X	X	X	X	X
(a) Ability to obtain blood typing and crossmatching;	X	X	X	X	X	X	X	X
(b) Autotransfusion;	X	X	X			X	X	X
(c) Blood and blood components available from in-house or through community services, to meet patient needs;	X	X	X	X	X	X	X	X
(d) Blood storage capability;	X	X	X	X		X	X	X
(e) Noncrossmatched blood available on patient arrival in the emergency department;	X	X	X	X	X	X	X	X
(f) Policies and procedures for massive transfusion.	X	X	X	X		X	X	X
(19) General surgery services with:	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(a) Surgeons who meet the following requirements:	X	X	X			X	X	X
(i) Are board-certified in general surgery and available within fifteen minutes of notification of the patient's arrival when the full trauma team is activated. This requirement can be met by a postgraduate year four or higher surgery resident. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the general surgeon. In this case the general surgeon must be available within fifteen minutes of notification of patient's arrival;	X							
(ii) Are board-certified in pediatric surgery or board-certified in general surgery with special competence in the care of pediatric patients and are available within fifteen minutes of notification of the patient's arrival when the full trauma team is activated. This requirement can be met by a post graduate year four or higher pediatric surgery resident or a general surgery resident with special competence in the care of pediatric patients. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the pediatric or general surgeon. In this case the pediatric or general surgeon must be available within fifteen minutes of notification of patient's arrival;						X		
(iii) Are board-certified in general surgery. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is fifteen minutes or more. Otherwise the surgeon must be in the emergency department within fifteen minutes of notification of patient's arrival. This requirement can be met by a postgraduate year four or higher surgery resident. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the general surgeon;		X						
(iv) Are board-certified in pediatric surgery **or** board-certified in general surgery with special competence in the care of pediatric patients. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is fifteen minutes or more. Otherwise the surgeon must be in the emergency department within fifteen minutes of notification of patient's arrival. This requirement can be met by a postgraduate year four or higher pediatric surgery resident or a general surgical resident with special competence in the care of pediatric patients. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the pediatric or general surgeon;							X	
(v) Are board-certified or trained in ACLS and currently certified in ATLS. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is thirty minutes or more. Otherwise the surgeon must be in the emergency department within thirty minutes of notification of patient's arrival;			X					
(vi) Are board-certified or board-qualified with special competence in the care of pediatric patients. For full trauma team activations, the surgeon must be in the emergency department upon patient arrival when prehospital estimated time of arrival (ETA) is thirty minutes or more. Otherwise the surgeon must be in the emergency department within thirty minutes of notification of patient's arrival;								X
(vii) Are trained in ACLS and currently certified in ATLS. This requirement applies to all surgeons and residents caring for trauma patients except this requirement does not apply to surgeons who are board certified in general surgery;	X	X	X					

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(viii) Are currently certified in ATLS. This requirement applies to all surgeons and residents caring for pediatric trauma patients except this requirement does not apply to surgeons who are board certified in pediatric or general surgery;						X	X	X
(ix) Meet the PER as defined in subsection (27) of this section;	X	X	X			X	X	X
(x) Have privileges in general surgery;	X	X	X					
(xi) Maintain at least eighty percent attendance at activations with a mechanism for documenting this attendance record, as required for full trauma activations. The expectation is for one hundred percent attendance at activations;	X	X	X			X	X	X
(xii) The attending surgeon is expected to be present in the operating room for all operations. A mechanism for documenting this presence is required;	X	X	X			X	X	X
(xiii) A surgeon from the trauma call panel must participate in the hospital's disaster planning process;	X	X	X			X	X	X
(xiv) Each member of the group of general surgeons must attend at least fifty percent of the peer review committee meetings;	X	X				X	X	
(xv) If at least fifty percent of the general surgeons did not attend the peer review committee meetings, then the trauma service must be able to demonstrate that there is a formal process for communicating information from the committee meetings to the group of general surgeons.			X					X
(b) A published schedule for first call with a written plan for surgery coverage if the surgeon on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma service's total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma service's trauma quality improvement program. In addition:	X	X	X			X	X	X
(i) Surgical commitment is required for a properly functioning trauma center;	X	X	X			X	X	X
(ii) The trauma surgeon on call must be dedicated to a single trauma center while on duty;	X	X				X	X	
(iii) The liaison from general surgery must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(iv) Other general surgeons who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal.	X	X				X	X	
(c) General surgery services that meet all level III general surgery service standards if the facility's trauma scope of service includes general surgery services twenty-four hours every day **or** transfer trauma patients who need general surgery services to a designated trauma service with general surgery services available.				X				
(20) Neurosurgery services with neurosurgeons who meet the following requirements:	X	X				X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(a) Are board-certified, and available within five minutes of the trauma team leader's request;	X					X		
This requirement can be met by a postgraduate year four or higher neurosurgery resident. The resident may initiate evaluation and treatment upon the patient's arrival in the emergency department until arrival of the neurosurgeon. In this case the neurosurgeon must be available within thirty minutes of the trauma team leader's request.	X					X		
(b) Are board-certified or board-qualified and on-call and available within thirty minutes of the trauma team leader's request;		X					X	
(c) Are board-certified or board-qualified and on-call and available within thirty minutes of the trauma team leader's request if the facility's trauma scope of service includes neurosurgery services twenty-four hours every day **or** transfer trauma patients who need neurosurgery services to a designated trauma service with neurosurgery services available;			X	X				X
(d) The liaison from neurosurgery must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(e) Other neurosurgeons who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(f) The facility must have a predefined and thoroughly developed neurotrauma diversion plan that is implemented when the neurosurgeon on call becomes encumbered. A neurotrauma diversion plan must include the following:	X	X				X	X	
(i) Emergency medical services notification of neurosurgery advisory status/divert;	X	X				X	X	
(ii) A thorough review of each instance by the quality improvement program; and	X	X				X	X	
(iii) Monitoring of the efficacy of the process by the quality improvement program.	X	X				X	X	
(g) A published schedule for first call with a written plan for neurosurgery coverage is required, for when the neurosurgeon on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma services total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma services trauma quality improvement program;	X	X				X	X	
(h) If one neurosurgeon covers two trauma services within the same limited geographic area, there must be a contingency plan.	X	X				X	X	
(21) Surgical services on-call and available within thirty minutes of the trauma team leader's request for:	X	X	X			X	X	X
(a) Cardiac surgery;	X					X		
(b) Microsurgery;	X					X		
(c) Obstetric surgery **or** for level III trauma services, a plan to manage the pregnant trauma patient;	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(d) Orthopedic surgery including the following:	X	X	X			X	X	X
(i) Orthopedic team members must have dedicated call at their institution or have an effective backup call system;	X	X				X	X	
(ii) If the on-call orthopedic surgeon is unable to respond promptly, a backup consultant on-call surgeon must be available;	X	X				X	X	
(iii) If the orthopedic surgeon is not dedicated to a single facility while on call, then a published backup schedule is required;			X					X
(iv) A published schedule for first call with a written plan for orthopedic surgery coverage is required for when the orthopedic surgeon on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma services total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma services trauma quality;	X	X	X			X	X	X
(v) The liaison from orthopedic surgery must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(vi) Other orthopedic surgeons who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal.	X	X				X	X	
(e) Orthopedic surgery services on-call and available within thirty minutes of the trauma team leader's request if the facility's trauma scope of service includes orthopedic surgery services twenty-four hours every day or transfer trauma patients who need orthopedic surgery services to a designated trauma service with orthopedic surgery services available;				X				
(f) Thoracic surgery;	X	X				X	X	
(g) Urologic surgery;	X	X				X	X	
(h) Vascular surgery.	X	X				X	X	
(22) Surgical services on-call for patient consultation or management at the trauma team leader's request for:	X	X				X	X	
(a) Cranial facial surgery;	X	X				X	X	
(b) Gynecologic surgery;	X	X				X	X	
(c) Ophthalmic surgery;	X	X				X	X	
(d) Plastic surgery.	X	X				X	X	
(23) Anesthesiology services with board-certified anesthesiologists or certified registered nurse anesthetists (CRNAs) who meet the following requirements:	X	X	X			X	X	X
(a) Are available within five minutes of the trauma team leader's request;	X					X		
(b) Are on-call and available within twenty minutes of the trauma team leader's request;		X					X	
(c) Are on-call and available within thirty minutes of the trauma team leader's request;			X					X
(d) Are ACLS trained except this requirement does not apply to physicians board-certified in anesthesiology;	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(e) Are highly experienced and committed to the care of injured patients; who organize and supervise the anesthetic care of injured patients; and who serve as the designated liaison to the trauma program;	X	X				X	X	
(f) When anesthesiology senior residents or CRNAs are used to fulfill availability requirements, the attending anesthesiologist on call must be advised, available within thirty minutes at all times, and present for all operations;	X	X				X	X	
(g) A published schedule for first call, with a written plan for anesthesia coverage is required for when the anesthesia provider on call for trauma is otherwise clinically engaged. The plan must take into consideration the trauma services total patient volume, patient acuity, geographic proximity to other trauma services, depth of trauma care resources, and the trauma scope of service. Diversion or transfer to definitive care should be the last option. The plan must be monitored through the trauma services trauma quality improvement program;	X	X	X			X	X	X
(h) Meet the PER as defined in subsection (27) of this section;	X	X	X			X	X	X
(i) Meet all level III anesthesiology service standards if the facility's trauma scope of service includes surgery services twenty-four hours every day **or** transfer trauma patients who need surgery services to a designated trauma service with surgery services available.				X				
(24) Operating room services with:	X	X	X			X	X	X
(a) Hospital staff responsible for opening and preparing the operating room available within five minutes of notification;	X	X	X			X	X	X
(b) Operating room staff on-call and available within fifteen minutes of notification;	X	X				X	X	
(c) Operating room staff on-call and available within thirty minutes of notification;			X					X
(d) A written plan to mobilize additional surgical team members for trauma patient surgery;	X	X	X			X	X	X
(e) Delays in operating room availability routinely monitored. Any case that is associated with a significant delay or adverse outcome must be reviewed for reasons for delay and opportunity for improvement;	X	X	X			X	X	X
(f) Standard surgery instruments and equipment needed to perform operations on adult and pediatric patients, including:	X	X	X			X	X	X
(i) Blood recovery and transfusion;	X	X	X			X	X	X
(ii) Bronchoscopy equipment;	X	X	X			X	X	X
(iii) Cardiopulmonary bypass;	X	X				X	X	
(iv) Craniotomy set;	X	X				X	X	
(v) Endoscopy equipment;	X	X	X			X	X	X
(vi) Rapid infusion capability;	X	X	X			X	X	X
(vii) Thermal control equipment:	X	X	X			X	X	X
(A) Blood and fluid warming;	X	X	X			X	X	X
(B) Patient warming and cooling.	X	X	X			X	X	X
(g) Operating room services that meet all level III operating room service standards if the facility's trauma scope of care includes surgery services twenty-four hours every day **or** transfer trauma patients who need surgery services to a designated trauma service with surgery services available.				X				
(25) Post anesthesia care (PACU) services with:	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(a) At least one registered nurse available twenty-four hours every day;	X					X		
(b) At least one registered nurse on-call and available twenty-four hours every day;		X	X				X	X
(c) Registered nurses who are ACLS trained;	X	X	X			X	X	X
(d) PACU equipment to monitor and resuscitate patients, including:								
(i) Pulse oximetry;								
(ii) End-tidal carbon dioxide detection;	X	X	X			X	X	X
(iii) Arterial pressure monitoring;								
(iv) Patient rewarming.								
(e) Post anesthesia care services that meet all level III post anesthesia care service standards if the facility's trauma scope of care includes general surgery services twenty-four hours every day **or** transfer trauma patients who need surgery services to a designated trauma service with surgery services available.				X				
(26) Critical care services with:	X	X	X			X	X	
(a) A critical care medical director who is:	X	X	X			X	X	
(i) Board-certified in:	X							
(A) Surgery and critical care;	X							
(B) Pediatric critical care.						X		
(ii) Board-certified in critical care **or** board-certified in surgery, internal medicine, or anesthesiology with special competence in critical care;		X	X					
(iii) Board-certified in critical care with special competence in pediatric critical care **or** is board-certified in surgery, internal medicine, or anesthesiology with special competence in pediatric critical care;							X	
(iv) Responsible for coordinating with the attending physician for trauma patient care.	X	X	X			X	X	
(b) Physician coverage of critically ill trauma patients in the intensive care unit (ICU) by appropriately trained physicians who meet the following requirements:	X	X	X			X	X	X
(i) Must be available in-house within fifteen minutes, twenty-four hours per day;	X					X		
(ii) Must be available within fifteen minutes, twenty-four hours per day;		X					X	
(iii) Must be available within thirty minutes with a formal plan in place for emergency coverage.			X					X
(c) For all levels of trauma service, the quality improvement program must ensure timely and appropriate ICU coverage is provided;	X	X	X			X	X	X
(d) The timely response of credentialed providers to the ICU must be continuously monitored as part of the quality improvement program;	X	X	X			X	X	X
(e) A designated ICU physician liaison or designee to the trauma service. This liaison must attend at least fifty percent of the multidisciplinary peer review meetings with documentation by the trauma quality improvement program;	X	X	X			X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(f) The physician liaison or designee from the ICU must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(g) Other ICU physicians who participate on the trauma team must be knowledgeable and current in the care of injured patients. This requirement may be met by completing thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;	X	X				X	X	
(h) Critical care registered nurses who:	X	X	X			X	X	
(i) Are ACLS trained;	X	X	X					
(ii) Have special competence in pediatric critical care;						X	X	
(iii) Have completed a minimum of six contact hours of trauma specific education every three-year designation period;	X	X				X	X	
(iv) Have completed a minimum of three contact hours of trauma specific education every three-year designation period.			X					
(i) A physician directed code team;	X	X	X			X	X	
(j) Pediatric patient isolation capacity;						X	X	
(k) General surgery consults for critical care trauma patients **or** if intensivists are the primary admitting nonsurgical physician caring for trauma patients, the intensivists must complete a minimum of twelve hours of external or internal trauma critical care specific CME every three-year designation period;	X	X	X			X	X	X
(l) Standard critical care equipment for adult and pediatric trauma patients, including:	X	X	X			X	X	
(i) Cardiac devices:	X	X	X			X	X	
(A) Cardiac pacing capabilities;	X	X	X			X	X	
(B) Cardiac monitor with at least two pressure monitoring modules (cardiac output and hard copy recording), with the capability to continuously monitor heart rate, respiratory rate, and temperature.	X	X	X			X	X	
(ii) Intracranial pressure monitoring devices;	X	X				X	X	
(iii) Intravenous supplies:	X	X	X			X	X	
(A) Infusion control device;	X	X	X			X	X	
(B) Rapid infusion capability.	X	X	X			X	X	
(iv) Sterile surgical sets:	X	X	X			X	X	
(A) Thoracostomy;	X	X	X			X	X	
(B) Emergency surgical airway;	X	X	X			X	X	
(C) Bedside ultrasound;	X	X	X			X	X	
(D) Thoracotomy.	X	X	X			X	X	
(v) Thermal control equipment:	X	X	X			X	X	
(A) Blood and fluid warming;	X	X	X			X	X	
(B) Devices for assuring warmth during transport;	X	X	X			X	X	
(C) Expanded scale thermometer capable of detecting hypothermia;	X	X	X			X	X	
(D) Patient warming and cooling.	X	X	X			X	X	

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(m) A written policy to transfer all pediatric trauma patients who need critical care services to a pediatric designated trauma service with critical care services available;	X	X	X					
(n) Surgical collaboration to set and implement policies and administrative decisions impacting trauma patients admitted to the ICU;	X	X	X			X	X	X
(o) Critical care services that meet all level III critical care service standards, if the facility's trauma scope of service includes critical care services for trauma patients twenty-four hours every day **or** transfer trauma patients who need critical care services to a designated trauma service with critical care services available;				X				
(p) Critical care services that meet all level II pediatric critical care service standards if the facility's trauma scope of care includes pediatric critical care services for trauma patients twenty-four hours every day **or** transfer pediatric trauma patients who need critical care services to a designated pediatric trauma service, with pediatric critical care services available.								X
(27) Pediatric education requirement (PER):	X	X	X	X	X	X	X	X
(a) The pediatric trauma medical director and the liaisons from neurosurgery, orthopedic surgery, emergency medicine, and critical care medicine must complete thirty-six hours of trauma-related CME every three years in either external CME or in an internal educational process conducted by the trauma program or meet the requirements for participation in maintenance of certification of a member board of the American Board of Medical Specialties at the time of renewal;						X	X	
(b) PER must be met by the following providers who are directly involved in the initial resuscitation and stabilization of pediatric trauma patients:	X	X	X	X	X	X	X	X
(i) Emergency department physicians;	X	X	X	X	X	X	X	X
(ii) Emergency department registered nurses;	X	X	X	X	X	X	X	X
(iii) Physician assistants or ARNPs who participate in the initial care or evaluation of trauma activated patients in the emergency department;	X	X	X	X	X	X	X	X
(iv) Emergency medicine or surgical residents who initiate care prior to the arrival of the emergency physician;	X	X				X	X	
(v) General surgeons;	X	X	X			X	X	X
(vi) Surgical residents who initiate care prior to the arrival of the general surgeon;	X	X				X	X	
(vii) Anesthesiologists and CRNAs;	X	X	X			X	X	X
(viii) General surgeons, anesthesiologists, and CRNAs if the facility's trauma scope of service includes general surgery services twenty-four hours every day;				X				
(ix) Intensivists involved in the resuscitation, stabilization and in-patient care of pediatric trauma patients.						X	X	X
(c) PER must be met by completing pediatric specific contact hours as defined below:	X	X	X	X	X	X	X	X
(i) Five contact hours per provider during each three-year designation period;	X	X	X	X	X			
(ii) Seven contact hours per provider during each three-year designation period;						X	X	X
(iii) Contact hours should include, but are not limited to, the following topics:	X	X	X	X	X	X	X	X
(A) Initial stabilization and transfer of pediatric trauma;	X	X	X	X	X	X	X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(B) Assessment and management of pediatric airway and breathing;	X	X	X	X	X	X	X	X
(C) Assessment and management of pediatric shock, including vascular access;	X	X	X	X	X	X	X	X
(D) Assessment and management of pediatric head injuries;	X	X	X	X	X	X	X	X
(E) Assessment and management of pediatric blunt abdominal trauma.	X	X	X	X	X	X	X	X
(iv) Contact hours may be accomplished through one or more, but not limited to, the following methods:	X	X	X	X	X	X	X	X
(A) Review and discussion of individual pediatric trauma cases within the trauma quality improvement program;	X	X	X	X	X	X	X	X
(B) Staff meetings;	X	X	X	X	X	X	X	X
(C) Classes, formal or informal;	X	X	X	X	X	X	X	X
(D) Web-based learning;	X	X	X	X	X	X	X	X
(E) Certification in ATLS, PALS, APLS, ENPC, or other department approved equivalents;	X	X	X	X	X	X	X	X
(F) Other methods of learning which appropriately communicates the required topics listed in this section.	X	X	X	X	X	X	X	X
(28) Acute dialysis services or must transfer trauma patients needing dialysis.	X	X	X	X	X	X	X	X
(29) A burn center, in accordance with the American Burn Association, to care for burn patients or must transfer burn patients to a burn center, in accordance with the American Burn Association transfer guidelines.	X	X	X	X	X	X	X	X
(30) Services on-call for consultation or patient management:	X	X	X			X	X	X
(a) Cardiology;	X	X				X	X	
(b) Gastroenterology;	X	X				X	X	
(c) Hematology;	X	X				X	X	
(d) Infectious disease specialists;	X	X				X	X	
(e) Internal medicine;	X	X	X					
(f) Nephrology;	X	X				X	X	
(g) Neurology;	X	X				X	X	
(h) Pediatric neurology;						X	X	
(i) Pathology;	X	X	X			X	X	X
(j) Pediatrician;	X	X				X	X	X
(k) Pulmonology;	X	X				X	X	
(l) Psychiatry **or** a plan for management of the psychiatric trauma patient.	X	X				X	X	
(31) Ancillary services available for trauma patient care:	X	X	X	X	X	X	X	X
(a) Adult protective services;	X	X	X	X	X			
(b) Child protective services;	X	X	X	X	X	X	X	X
(c) Chemical dependency services;	X	X	X			X	X	X
(d) Nutritionist services;	X	X	X	X		X	X	X
(e) Occupational therapy services;	X	X	X			X	X	X
(f) Pastoral or spiritual care;	X	X	X	X	X	X	X	X
(g) Pediatric therapeutic recreation/child life specialist;						X	X	
(h) Pharmacy services, with an in-house pharmacist;	X					X		
(i) Pharmacy services;		X	X	X	X		X	X

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(j) Physical therapy services;	X	X	X	X		X	X	X
(k) Psychological services;	X	X	X			X	X	X
(l) Social services;	X	X	X	X		X	X	X
(m) Speech therapy services.	X	X	X			X	X	X
(32) A trauma care outreach program, including:	X	X				X	X	
(a) Telephone consultations with physicians of the community and outlying areas;	X	X				X	X	
(b) On-site consultations with physicians of the community and outlying areas.	X	X				X	X	
(33) Injury prevention, including:	X	X	X	X	X	X	X	X
(a) A public injury prevention education program to include:	X	X	X			X	X	X
(i) An employee in a leadership position that has injury prevention as part of their job description;	X	X	X	X	X	X	X	X
(ii) Registry data used to identify injury prevention priorities that are appropriate for local implementation;	X	X	X	X	X	X	X	X
(iii) Trauma centers that have an organized and effective approach to injury prevention and prioritize those efforts based on local trauma registry and epidemiologic data.	X	X	X	X	X	X	X	X
(b) Participation in community or regional injury prevention activities that include partnerships with other community organizations;	X	X	X	X	X	X	X	X
(c) A written plan for drug and alcohol screening and brief intervention and referral for treatment;	X	X	X	X	X	X	X	X
(d) Screening and brief intervention for drug and alcohol use. All patients who have screened positive must receive an intervention by appropriately trained staff and this intervention must be documented.	X	X	X	X	X	X	X	X
(34) A formal trauma education training program for:	X	X				X	X	
(a) Allied health care professional;	X	X				X	X	
(b) Community physicians;	X	X				X	X	
(c) Nurses;	X	X				X	X	
(d) Prehospital personnel;	X	X				X	X	
(e) Staff physicians.	X	X				X	X	
(35) Provisions to allow for initial and maintenance training of invasive manipulative skills for prehospital personnel.	X	X	X	X		X	X	X
(36) Residency programs that must:	X					X		
(a) Be accredited by the Accreditation Council of Graduate Medical Education;	X					X		
(b) Be committed to training physicians in trauma management.	X					X		
(37) A trauma research program conducting research applicable to the adult and pediatric trauma patient population, including:	X					X		
(a) At a minimum, a trauma research program that publishes twenty peer-reviewed articles in journals included in Index Medicus or PubMed within a three-year period;	X					X		
(b) These publications must result from work related to the trauma center or the trauma system in which the trauma center participates;	X					X		
(c) Of the twenty articles, at least one must be authored or co-authored by members of the general surgery trauma team;	X					X		

WAC 246-976-700 Trauma Service Standards	Adult Levels					Pediatric Levels		
A facility with a designated trauma service must have:	**I**	**II**	**III**	**IV**	**V**	**I P**	**II P**	**III P**
(d) At least one article each from three of the following disciplines is required: Basic sciences, neurosurgery, emergency medicine, orthopedics, radiology, anesthesia, vascular surgery, plastics/maxillofacial surgery, critical care, cardiothoracic surgery, rehabilitation, and nursing;	X					X		
(e) In combined level I adult and pediatric centers, half of the required research must be pediatric research;	X					X		
(f) The administration of a level I trauma center must demonstrate support for the research program by including the provision of basic laboratory space, sophisticated research equipment, advanced information systems, biostatical support, salary support for basic and translational scientists, or seed grants for less experienced faculty.	X					X		
(38) For joint trauma service designation (when two or more hospitals apply to share a single trauma designation):	X	X	X			X	X	X
(a) A single, joint multidisciplinary trauma quality improvement program in accordance with the trauma quality improvement standards defined in subsection (4) of this section;	X	X	X			X	X	X
(b) A set of common policies and procedures adhered to by all hospitals and providers in the joint trauma service;	X	X	X			X	X	X
(c) A predetermined, published hospital rotation schedule for trauma care.	X	X	X			X	X	X
(39) Trauma centers must meet the disaster-related requirements of the facility's accrediting agency.	X	X	X	X	X	X	X	X
(40) Organ procurement activities, including:	X	X	X			X	X	X
(a) An established relationship with a recognized organ procurement organization (OPO);	X	X	X			X	X	X
(b) A written policy in place for notification of the regional OPO;	X	X	X			X	X	X
(c) The trauma center must review its organ donation rate annually;	X	X	X			X	X	X
(d) Written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death.	X	X	X			X	X	X

[Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 18-24-082, § 246-976-700, filed 12/3/18, effective 1/3/19. Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070. WSR 09-23-085, § 246-976-700, filed 11/16/09, effective 12/17/09.]

WAC 246-976-800 Trauma rehabilitation service standards.

WAC 246-976-800 Trauma Rehabilitation Service Standards	Levels			
A designated trauma rehabilitation service must:	**I**	**II**	**III**	**I Pediatric**
(1) Be a licensed hospital as defined in chapter 246-320 WAC.	X			X
(2) Treat adult and adolescent trauma patients in inpatient and outpatient settings regardless of disability or level of severity or complexity.	X			
(3) Treat pediatric and adolescent trauma patients in inpatient and outpatient settings regardless of disability or level of severity or complexity.				X
(4) Treat adult and adolescent trauma patients in inpatient and outpatient settings with disabilities or level of severity or complexity within the facility's capability and as specified in the facility's admission criteria.		X		

WAC 246-976-800 Trauma Rehabilitation Service Standards	Levels			
A designated trauma rehabilitation service must:	**I**	**II**	**III**	**I Pediatric**
(5) For adolescent patients (approximately twelve to eighteen years of age), the service must consider whether physical development, educational goals, preinjury learning or developmental status, social or family needs, and other factors indicate treatment in an adult or pediatric rehabilitation service.	X	X		X
(6) Have and retain full accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) for inpatient medical rehabilitation programs.	X	X		
(7) Have and retain full accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) for pediatric inpatient medical rehabilitation programs.				X
(8) House patients on a designated rehabilitation nursing unit.	X	X		
(9) House patients in a designated pediatric rehabilitation area, providing an environment appropriate to the age and developmental status of the patient.				X
(10) Provide a peer group for persons with similar disabilities.	X	X		X
(11) Have a medical director who: (a) Is a physiatrist; (b) Is responsible for the organization and direction of the trauma rehabilitation service; and (c) Participates in the trauma rehabilitation service's quality improvement program.	X	X		X
(12) Have a physiatrist in-house or on-call twenty-four hours every day and responsible for the day-to-day clinical management and the treatment plan of trauma patients.	X	X		X
(13) Provide rehabilitation nursing personnel twenty-four hours every day, with:	X	X		X
(a) Management and supervision by a registered nurse;	X	X		X
(b) The initial care plan and weekly update reviewed and approved by a certified rehabilitation registered nurse (CRRN);	X	X		X
(c) An orientation and training program for all levels of rehabilitation nursing personnel;	X	X		X
(d) A minimum of six clinical nursing care hours, per patient day, for each trauma patient;	X	X		X
(e) At least one CRRN on duty, each day and evening shift, when a trauma patient is present;	X			X
(f) At least one CRRN on duty, one shift each day, when a trauma patient is present.		X		
(14) Provide the following trauma rehabilitation services with providers who are licensed, registered, certified, or degreed and are available to provide treatment as defined in the patient's rehabilitation plan:	X	X		X
(a) Occupational therapy;	X	X		X
(b) Physical therapy;	X	X		X
(c) Speech/language pathology;	X	X		X
(d) Social services;	X	X		X
(e) Nutritional counseling;	X	X		X
(f) Clinical psychological services, including testing and counseling;	X	X		X
(g) Neuropsychological services.	X	X		X
(15) Provide the following health personnel and consultative services in-house or on-call twenty-four hours every day:	X	X		X
(a) A pharmacist with immediate access to pharmaceuticals and patient medical records and pharmacy databases;	X	X		X
(b) Respiratory care practitioners;	X	X		X
(c) Pastoral or spiritual care;	X	X		X
(d) A radiologist;	X	X		X
(e) A pediatrician.				X
(16) Provide the following services in-house or through affiliation or consultative arrangements with providers who are licensed, registered, certified, or degreed:	X	X		X
(a) Anesthesiology (anesthesiologist or CRNA);	X	X		X

WAC 246-976-800 Trauma Rehabilitation Service Standards	Levels			
A designated trauma rehabilitation service must:	**I**	**II**	**III**	**I Pediatric**
(b) Audiology;	X	X		X
(c) Communication augmentation;	X	X		X
(d) Dentistry;	X	X		X
(e) Diagnostic imaging, including: (i) Computerized tomography; (ii) Magnetic resonance imaging; (iii) Nuclear medicine; and (iv) Radiology;	X	X		X
(f) Driver evaluation and training;	X	X		
(g) Educational program appropriate to the disability and developmental level of the pediatric or adolescent patient, to include educational screening, instruction, and discharge planning coordinated with the receiving school district;	X	X		X
(h) Electrophysiologic testing, including: (i) Electroencephalography; (ii) Electromyography; and (iii) Evoked potentials;	X	X		X
(i) Laboratory services;	X	X		X
(j) Orthotics;	X	X		X
(k) Prosthetics;	X	X		X
(l) Pediatric therapeutic recreation specialist or child life specialist;				X
(m) Rehabilitation engineering for device development and adaptations;	X	X		X
(n) Substance abuse counseling;	X	X		X
(o) Therapeutic recreation;	X	X		X
(p) Vocational rehabilitation;	X	X		
(q) Urodynamic testing.	X	X		X
(17) Have providers with documented special competence in pediatric rehabilitation care. This requirement applies to all pediatric trauma rehabilitation providers.				X
(18) Serve as a regional referral center for patients in their geographical area needing only level II or III rehabilitation care.	X			
(19) Have an outreach program regarding trauma rehabilitation care, consisting of telephone and on-site consultations with physicians and other health care professionals in the community and outlying areas.	X	X		X
(20) Have a formal program of continuing trauma rehabilitation care education, both in-house and outreach, provided for nurses and allied health care professionals.	X	X		X
(21) Have an ongoing structured program to conduct clinical studies, applied research, or analysis in rehabilitation of trauma patients, and report results within a peer review process.	X			X
(22) Have a quality improvement program that reflects and demonstrates a process for continuous quality improvement in the delivery of trauma rehabilitation care, with: (a) An organizational structure and plan that facilitates the process of quality improvement and identifies the authority to change policies, procedures, and protocols that address the care of the trauma patient; (b) Representation and participation by the interdisciplinary trauma rehabilitation team; (c) A process for communicating and coordinating with referring trauma care providers as needed; (d) Development of outcome standards; (e) A process for monitoring compliance with or adherence to the outcome standards; (f) A process of internal peer review to evaluate specific cases or problems; (g) A process for implementing corrective action to address problems or deficiencies;	X	X		X

WAC 246-976-800 Trauma Rehabilitation Service Standards	Levels			
A designated trauma rehabilitation service must:	**I**	**II**	**III**	**I Pediatric**
(h) A process to analyze and evaluate the effect of corrective action; and (i) A process to ensure that confidentiality of patient and provider information is maintained according to the standards of RCW 70.41.200 and 70.168.090.				
(23) Participate in the regional trauma quality improvement program as defined in WAC 246-976-910.	X	X	X	X
(24) Participate in the Washington state trauma registry as defined in WAC 246-976-430.	X	X	X	X
(25) Provide a community based program of coordinated and integrated outpatient trauma rehabilitation services, evaluation, and treatment to persons with trauma-related functional limitations who do not need or no longer require comprehensive inpatient rehabilitation. Services may be provided in, but not limited to, the following settings: (a) Freestanding outpatient rehabilitation centers; (b) Organized outpatient rehabilitation programs in acute hospital settings; (c) Day hospital programs; (d) Other community settings.			X	
(26) Treat patients according to admission criteria based on diagnosis and severity.			X	
(27) Be directed by a physician with training and experience necessary to provide rehabilitative physician services, acquired through one of the following: (a) Formal residency in physical medicine and rehabilitation; or (b) A fellowship in rehabilitation for a minimum of one year; or (c) A minimum of two years' experience in providing rehabilitation services for patients typically seen in CARF-accredited inpatient rehabilitation programs.			X	
(28) Provide the following trauma rehabilitation services with providers who are licensed, registered, or certified according to the frequency as defined in the rehabilitation plan: (a) Occupational therapy; (b) Physical therapy; (c) Social services; (d) Speech/language pathology.			X	
(29) Provide or assist the patient to obtain the following as defined in the rehabilitation plan: (a) Audiology; (b) Dentistry; (c) Driver evaluation and training; (d) Education; (e) Nursing; (f) Nutrition counseling; (g) Orthotics; (h) Pastoral or spiritual care; (i) Prosthetics; (j) Psychology; (k) Rehabilitation engineering for device development and adaptations; (l) Respiratory therapy; (m) Substance abuse counseling; (n) Therapeutic recreation; (o) Vocational rehabilitation.			X	
(30) Have a quality improvement program that reflects and demonstrates a process for continuous quality improvement in the delivery of trauma care, with: (a) A process to identify and monitor trauma rehabilitation care and outcome standards and indicators;			X	

WAC 246-976-800 Trauma Rehabilitation Service Standards	Levels			
A designated trauma rehabilitation service must:	**I**	**II**	**III**	**I Pediatric**
(b) An interdisciplinary team, to include the trauma rehabilitation service physician director; (c) A process to ensure confidentiality of patient and provider information in accordance with RCW 70.41.200 and 70.168.090.				

[Statutory Authority: RCW 70.168.050, 70.168.060, and 70.168.070. WSR 09-23-085, § 246-976-800, filed 11/16/09, effective 12/17/09.]

SYSTEM ADMINISTRATION

WAC 246-976-890 Interhospital transfer guidelines and agreements. Designated trauma services must:

(1) Have written guidelines consistent with their written scope of trauma service to identify and transfer patients with special care needs exceeding the capabilities of the trauma service;

(2) Have written transfer agreements with other designated trauma services. The agreements must address the responsibility of the transferring hospital, the receiving hospital, and the prehospital transport agency, including a mechanism to assign medical control during interhospital transfer;

(3) Have written guidelines, consistent with their written scope of trauma service, to identify trauma patients who are transferred in from other facilities, whether admitted through the emergency department or directly into other hospital services;

(4) Use verified prehospital trauma services for interfacility transfer of trauma patients.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-890, filed 3/22/11, effective 5/15/11. Statutory Authority: RCW 70.168.060 and 70.168.070. WSR 04-01-041, § 246-976-890, filed 12/10/03, effective 1/10/04. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-890, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapter 70.168 RCW. WSR 98-04-038, § 246-976-890, filed 1/29/98, effective 3/1/98. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-890, filed 12/23/92, effective 1/23/93.]

WAC 246-976-910 Regional quality assurance and improvement program. (1) The department will:

(a) Develop guidelines for a regional EMS/TC system quality assurance and improvement program including:

(i) Purpose and principles of the program;

(ii) Establishing and maintaining the program;

(iii) Process;

(iv) Membership of the quality assurance and improvement program committee;

(v) Authority and responsibilities of the quality assurance and improvement program committee;

(b) Review and approve written regional quality assurance and improvement plans;

(c) Provide trauma registry data to regional quality assurance and improvement programs in the following formats:

(i) Quarterly standard reports;

(ii) Ad hoc reports as requested according to department guidelines.

(2) Levels I, II, and III, and Level I, II and III pediatric trauma care services must:

(a) Establish, coordinate and participate in regional EMS/TC systems quality assurance and improvement programs;

(b) Ensure participation in the regional quality assurance and improvement program of:

(i) Their trauma service director or codirector; and

(ii) The RN who coordinates the trauma service;

(c) Ensure maintenance and continuation of the regional quality assurance and improvement program.

(3) The regional quality assurance and improvement program committee must include:

(a) At least one member of each designated facility's medical staff;

(b) The RN coordinator of each designated trauma service;

(c) An EMS provider.

(4) The regional quality assurance program must invite the MPD and all other health care providers and facilities providing trauma care in the region, to participate in the regional trauma quality assurance program.

(5) The regional quality assurance and improvement program may invite:

(a) One or more regional EMS/TC council members;

(b) A trauma care provider who does not work or reside in the region.

(6) The regional quality assurance and improvement program must include a written plan for implementation including:

(a) Operational policies and procedures that detail committee actions and processes;

(b) Audit filters for adult and pediatric patients;

(c) Monitoring compliance with the requirements of chapter 70.168 RCW and this chapter;

(d) Policies and procedures for notifying the department and the regional EMS/TC council of identified regional or statewide trauma system issues, and any recommendations;

(e) Policies regarding confidentiality of:

(i) Information related to provider's and facility's clinical care, and patient outcomes, in accordance with chapter 70.168 RCW;

(ii) Quality assurance and improvement committee minutes, records, and reports in accordance with RCW 70.168.090(4), including a requirement that each attendee of a regional quality assurance and improvement committee meeting is informed in writing of the confidentiality requirement. Information identifying individual patients may not be publicly disclosed without the patient's consent.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-910, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-910, filed 12/23/92, effective 1/23/93.]

WAC 246-976-920 Medical program director. (1) Qualifications - Applicants for certification as a medical program director (MPD) must:

(a) Hold and maintain a current and valid license to practice medicine and surgery under chapter 18.71 RCW or osteopathic medicine and surgery under chapter 18.57 RCW; and

(b) Be qualified and knowledgeable in the administration and management of emergency medical care and services; and

(c) Complete a medical director training course approved by the department; and

(d) Be recommended for certification by the local medical community and local emergency medical services and trauma care council.

(2) MPD certification process. In certifying the MPD, the department will:

(a) Work with the local EMSTC council to identify physicians interested in serving as the MPD;

(b) Receive a letter of interest and curriculum vitae from the MPD candidate;

(c) Perform required background checks identified in RCW 18.130.064;

(d) Work with and provide technical assistance to local EMSTC councils on evaluating MPD candidates;

(e) Obtain letters of recommendation from the local EMSTC council and local medical community;

(f) Make final appointment of the MPD.

(3) The certified MPD must:

(a) Provide medical control and direction of EMS certified personnel in their medical duties. This is done by oral or written communication;

(b) Develop and adopt written prehospital patient care protocols to direct EMS certified personnel in patient care. These protocols may not conflict with regional patient care procedures. Protocols may not exceed the authorized care of the certified prehospital personnel as described in WAC 246-976-182;

(c) Establish policies for storing, dispensing, and administering controlled substances. Policies must be in accordance with state and federal regulations and guidelines;

(d) Participate with local and regional EMS/TC councils to develop and revise:

(i) Regional patient care procedures;

(ii) County operating procedures when applicable. COPS do not conflict with regional patient care procedures; and

(iii) Participate with the local and regional EMS/TC councils to develop and revise regional plans;

(e) Work within the parameters of the approved regional patient care procedures and the regional plan;

(f) Supervise training of all EMS certified personnel;

(g) Develop protocols for special training described in WAC 246-976-023(4);

(h) Periodically audit the medical care performance of EMS certified personnel;

(i) Recommend to the secretary certification, recertification, or denial of certification of EMS personnel;

(j) Recommend to the secretary disciplinary action to be taken against EMS personnel, which may include modification, suspension, or revocation of certification; and

(k) Recommend to the department individuals applying for recognition as senior EMS instructors.

(4) In accordance with department policies and procedures, the MPD may:

(a) Delegate duties to other physicians, except for duties described in subsection (3)(b), (i), (j), and (k) of this section. The delegation must be in writing;

(i) The MPD must notify the department in writing of the names and duties of individuals so delegated, within fourteen days of appointment;

(ii) The MPD may remove delegated authority at any time, which shall be effective upon written notice to the delegate and the department.

(b) Delegate duties relating to training, evaluation, or examination of certified EMS personnel, to qualified nonphysicians. The delegation must be in writing;

(c) Enter into EMS medical control agreements with other MPDs;

(d) Recommend denial of certification to the secretary for any applicant the MPD can document is unable to function as an EMS provider, regardless of successful completion of training, evaluation, or examinations; and

(e) Utilize examinations to determine the knowledge and abilities of certified EMS personnel prior to recommending applicants for certification or recertification.

(5) The secretary may withdraw the certification of an MPD for failure to comply with the Uniform Disciplinary Act (chapter 18.130 RCW) and other applicable statutes and regulations.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 11-07-078, § 246-976-920, filed 3/22/11, effective 5/15/11; WSR 00-08-102, § 246-976-920, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-920, filed 12/23/92, effective 1/23/93.]

WAC 246-976-930 General responsibilities of the department. In addition to the requirements described in chapters 18.71, 18.73, and 70.168 RCW, and elsewhere in this chapter:

(1) The department shall review, recommend changes to, and approve regional plans and regional patient care procedures based on the requirements of this chapter and recommendations from the steering committee, and upon consideration of the needs of patients.

(a) The department may approve regional plans which include standards that are consistent with chapter 70.168 RCW and other state and federal laws, but which exceed the requirements of this chapter.

(b) The department will develop a process for biennial update of regional and statewide planning. The process will include provisions to amend regional plans between biennial updates.

(2) The department will publish prehospital trauma triage procedures for activation of the trauma system from the field. The procedures will include assessment of the patient's:

(a) Vital signs and level of consciousness;

(b) Anatomy of injury;

(c) Biomechanics of the injury; and

(d) Comorbid and associated risk factors.

(3) The department may approve pilot programs and projects which have:

(a) Stated objectives;

(b) A specified beginning and ending date;
(c) An identified way to measure the outcome;
(d) A review process;
(e) A work plan with a time line;
(f) If training of EMS personnel is involved, consistency with the requirements of WAC 246-976-021(5).
(4) The department will review at least every four years:
(a) Rules, policies, and standards for EMS, with the advice of the steering committee;
(b) Rules and standards for licensure of services and vehicles, and for certification of EMS personnel, with the advice of the L&C committee.

[Statutory Authority: Chapters 18.71 and 18.73 RCW. WSR 04-08-103, § 246-976-930, filed 4/6/04, effective 5/7/04. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-930, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-930, filed 12/23/92, effective 1/23/93.]

WAC 246-976-935 Emergency medical services and trauma care system trust account. RCW 70.168.040 establishes the emergency medical services and trauma care system trust account. With the advice of the EMS/TC steering committee, the department will develop a method to budget and distribute funds in the trust account. The department may use an injury severity score to define a major trauma patient. Initially, the method and budget will be based on the department's *Trauma Care Cost Reimbursement Study, final report (October 1991).* The committee and the department will review the method and the budget at least every two years.
(1) Definitions: The following phrases used in this section mean:
(a) "Needs grant" is a trust account payment that is based on a demonstrated need to develop and maintain service that meets the trauma care standards of chapter 70.168 RCW and this chapter. Needs grants are awarded to verified trauma care ambulance or aid services. Services must be able to show that they have looked for other resources without success before they will be considered for a needs grant.
(b) "Participation grant" refers to a trust account payment designed to compensate the recipient for participation in the state's comprehensive trauma care system. These grants are intended as a tool for assuring access to trauma care. Participation grants are awarded to:
(i) Verified trauma care ambulance or aid services;
(ii) Designated trauma care services; and
(iii) Designated trauma rehabilitation services.
(2) The department will distribute trust account funds to:
(a) Verified trauma care ambulance and aid services;
(b) Designated trauma care services:
(i) Levels I-V general; and
(ii) Levels I-III pediatric;
(c) Designated trauma rehabilitation services:
(i) Levels I-III; and
(ii) Level I-pediatric.
(3) The department's distribution method for verified trauma care ambulance and aid services will include at least:

(a) Participation grants, which will be awarded once a year to services that comply with verification standards;

(b) Needs grants, based on the service's ability to meet the standards of chapter 70.168 RCW and chapter 246-976 WAC (this chapter). The department may consider:

(i) Level of service (BLS, ILS, ALS);

(ii) Type of service (aid or ambulance);

(iii) Response area (rural, suburban, urban, wilderness);

(iv) Volume of service;

(v) Other factors that relate to trauma care;

(4) The department's distribution method for designated trauma care services will include:

(a) Participation grants to levels I-V general and I-III pediatric, which will be awarded once a year only to services that comply with designation standards. The department will review the compliance requirements annually. The department may consider:

(i) Level of designation;

(ii) Service area (rural, suburban, urban, wilderness);

(iii) Volume of service;

(iv) The percentage of uncompensated major trauma care;

(v) Other factors that relate to trauma care;

(b) Trauma care grants, which will be awarded once a year to level I-III designated acute trauma services to subsidize uncompensated trauma care costs. To be eligible for the grants, trauma services must comply with Washington state's DOH trauma registry requirements per WAC 246-976-420 through 246-976-430 including submission of complete financial data and injury coding data. The grants will be calculated by multiplying a hospital's bad debt and charity care ratio times the sum of injury severity scores (ISS) for a specific period. The results for all eligible trauma services are summed, and each trauma service will receive a proportionate share of the available uncompensated trauma care grant allocation based on their percentage of the overall total. The bad debt and charity care ratio is calculated by summing a hospital's bad debt and charity care figures divided by the hospital's total patient revenue for the same period. These figures are from annual financial data reported to the department per chapters 246-453 and 246-454 WAC. Injury severity scores are extracted from trauma registry data for cases that:

(i) Meet the trauma registry inclusion criteria per WAC 246-976-420; and

(ii) Are admitted with an ISS of thirteen or greater for adults, nine or greater for pediatric patients less than fifteen years of age, or trauma patients received in transfer regardless of the ISS.

(c) Trauma care grants, which will be awarded once a year to designated acute trauma services levels IV, V, and/or critical access hospitals (CAH) to subsidize their costs for providing care to the trauma patients, and for stabilizing and transferring major trauma patients. The individual grant amounts are based on designation level.

(5) The department may issue grants to DOH-certified medical program directors (MPD) for their role in the EMS/TCS as described in WAC 246-976-920.

(6) The department's distribution method for designated trauma rehabilitation services, levels I-III and I-pediatric will include at least:

Participation grants, which will be awarded once a year only to services that comply with designation standards. The department will

review the compliance requirements annually. The department may consider:

(a) Level of designation;

(b) Volume of service;

(c) Other factors that relate to trauma care.

[Statutory Authority: Chapter 70.168 RCW. WSR 04-12-126, § 246-976-935, filed 6/2/04, effective 7/3/04. Statutory Authority: RCW 70.168.040. WSR 02-04-045, § 246-976-935, filed 1/29/02, effective 3/1/02. Statutory Authority: Chapter 70.168 RCW. WSR 98-05-035, § 246-976-935, filed 2/10/98, effective 3/13/98.]

WAC 246-976-940 Steering committee. In addition to the requirements of chapter 70.168 RCW and elsewhere in this chapter, the EMS/TC steering committee will:

(1) Review and comment on the department's rules, policies, and standards;

(2) Review and comment on the department's budget for the EMS/TC system at least biennially;

(3) Periodically review and recommend changes to:

(a) The department's prehospital triage procedures;

(b) Regional patient care procedures;

(c) Regional plans; and

(d) Interfacility transfer guidelines.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-940, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-940, filed 12/23/92, effective 1/23/93.]

WAC 246-976-960 Regional emergency medical services and trauma care councils. (1) In addition to meeting the requirements of chapter 70.168 RCW and elsewhere in this chapter, regional EMS/TC councils must:

(a) Identify and analyze system trends to evaluate the EMS/TC system and its component subsystems, using trauma registry data provided by the department;

(b) Develop and submit to the department regional EMS/TC plans to:

(i) Identify the need for and recommend distribution and level of care (basic, intermediate or advanced life support) for verified aid and ambulance services for each response area. The recommendations will be based on criteria established by the department relating to agency response times, geography, topography, and population density;

(ii) Identify EMS/TC services and resources currently available within the region;

(iii) Describe how the roles and responsibilities of the MPD are coordinated with those of the regional EMS/TC council and the regional plan;

(iv) Describe and recommend improvements in medical control communications and EMS/TC dispatch, with at least the elements of the state communication plan described in RCW 70.168.060 (1)(h);

(v) Include a schedule for implementation.

(2) In developing or modifying its plan, the regional council must seek and consider the recommendations of:

(a) Local EMS/TC councils;

(b) EMS/TC systems established by ordinance, resolution, interlocal agreement or contract by counties, cities, or other governmental bodies.

(3) In developing or modifying its plan, the regional council must use regional and state analyses provided by the department based on trauma registry data and other appropriate sources;

(4) Approved regional plans may include standards, including response times for verified services, which exceed the requirements of this chapter.

(5) An EMS/TC provider who disagrees with the regional plan may bring its concerns to the steering committee before the department approves the plan.

(6) The regional council must adopt regional patient care procedures as part of the regional plans. In addition to meeting the requirements of RCW 18.73.030(14) and 70.168.015(23):

(a) For all emergency patients, regional patient care procedures must identify:

(i) Guidelines for rendezvous with agencies offering higher levels of service if appropriate and available, in accordance with the regional plan.

(ii) The type of facility to receive the patient, as described in regional patient destination and disposition guidelines.

(iii) Procedures to handle types and volumes of trauma that may exceed regional capabilities, taking into consideration resources available in other regions and adjacent states.

(b) For major trauma patients, regional patient care procedures must identify procedures to activate the trauma system.

(7) In areas where no local EMS/TC council exists, the regional EMS/TC council shall:

(a) Make recommendations to the department regarding appointing members to the regional EMS/TC council;

(b) Review applications for initial training classes and OTEP programs, and make recommendations to the department.

(8) Matching grants made under the provisions of chapter 70.168 RCW may include funding to:

(a) Develop, implement, and evaluate prevention programs; or

(b) Accomplish other purposes as approved by the department.

[Statutory Authority: RCW 18.73.081 and 70.168.120. WSR 02-14-053, § 246-976-960, filed 6/27/02, effective 7/28/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-960, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-960, filed 12/23/92, effective 1/23/93.]

WAC 246-976-970 Local emergency medical services and trauma care councils. (1) If a county or group of counties creates a local EMS/TC council, it must be composed of representatives of hospital and prehospital trauma care and EMS providers, local elected officials, consumers, local law enforcement officials, local government agencies, physicians, and prevention specialists involved in the delivery of EMS/TC.

(2) In addition to meeting the requirements of chapter 70.168 RCW and this chapter, local EMS/TC councils must:

(a) Participate with the MPD and emergency communication centers in making recommendations to the regional council about the development of regional patient care procedures; and

(b) Review applications for initial training classes and OTEP programs, and make recommendations to the department.

(3) Local EMS/TC councils may make recommendations to the department regarding certification and termination of MPDs, as provided in RCW 18.71.205(4).

[Statutory Authority: RCW 18.73.081 and 70.168.120. WSR 02-14-053, § 246-976-970, filed 6/27/02, effective 7/28/02. Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-970, filed 4/5/00, effective 5/6/00. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-970, filed 12/23/92, effective 1/23/93.]

WAC 246-976-990 Fees and fines. (1) The department shall assess individual health care facilities submitting a proposal to be designated as a level I general trauma care facility a fee, not to exceed seven thousand dollars, to help defray the costs to the department of inspections and review of applications.

(2) The department shall assess individual health care facilities submitting a proposal to be designated as a level II general trauma care facility a fee, not to exceed six thousand dollars, to help defray the costs to the department of inspections and review of applications.

(3) The department shall assess individual health care facilities submitting a proposal to be designated as a level III general trauma care facility a fee, not to exceed one thousand nine hundred fifty dollars, to help defray the costs to the department of inspections and review of applications.

(4) The department shall assess individual health care facilities submitting a proposal to be designated as a level I pediatric trauma care facility a fee, not to exceed nine thousand two hundred dollars, to help defray the costs to the department of inspections and review of applications.

(5) The department shall assess individual health care facilities submitting a proposal to be designated as a level II pediatric trauma care facility a fee, not to exceed eight thousand dollars, to help defray the costs to the department of inspections and review of applications.

(6) The department shall assess individual health care facilities submitting a proposal to be designated as a level III pediatric trauma care facility a fee, not to exceed two thousand dollars, to help defray the costs to the department of inspections and review of applications.

(7) The department shall assess health care facilities submitting a joint proposal to be jointly designated as a level I general or pediatric trauma care facility a fee, of at least seven thousand dollars, and based upon a determined hourly rate and per diem expense per inspection team member, not to exceed fourteen thousand five hundred dollars to help defray the costs to the department of inspections and review of applications.

(8) The department shall assess health care facilities submitting a joint proposal to be jointly designated as a level II general or pediatric trauma care facility a fee, of at least six thousand dollars, and based upon a determined hourly rate and per diem expense per inspection team member, not to exceed twelve thousand five hundred dollars to help defray the costs to the department of inspections and review of applications.

(9) The department shall assess health care facilities submitting a joint proposal to be jointly designated as a level III general or pediatric trauma care facility a fee, of at least one thousand nine hundred fifty dollars, and based upon a determined hourly rate and per diem expense per inspection team member, not to exceed three thousand one hundred dollars to help defray the costs to the department of inspections and review of applications.

(10) The department shall assess health care facilities submitting a proposal to be designated at multiple levels to provide adult and pediatric care a fee, not to exceed nine thousand two hundred dollars to help defray the costs to the department of inspections and review of applications.

(11) The department shall not assess such fees to health care facilities applying to provide level IV and V trauma care services.

(12) If an ambulance or aid service fails to comply with the requirements of chapters 18.71, 18.73, 70.168 RCW, the Uniform Disciplinary Act, or with the requirements of this chapter, the department may notify the appropriate local, state or federal agencies.

[Statutory Authority: Chapters 18.71, 18.73, and 70.168 RCW. WSR 00-08-102, § 246-976-990, filed 4/5/00, effective 5/6/00. Statutory Authority: Chapter 70.168 RCW. WSR 93-20-063, § 246-976-990, filed 10/1/93, effective 11/1/93. Statutory Authority: RCW 43.70.040 and chapters 18.71, 18.73 and 70.168 RCW. WSR 93-01-148 (Order 323), § 246-976-990, filed 12/23/92, effective 1/23/93.]